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: 140007	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/27/2016 11:45 am

PART I - COST REPORT STATUS

Provider use only

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

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PRESENCE ST. JOSEPH MEDICAL CENTER (140007) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	720,029	1,049,015	129,306	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-47,308	57		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	672,721	1,049,072	129,306	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2016 11:45 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 333 NORTH MADISON STREET	PO Box:			1.00
2.00	City: JOLIET	State: IL	Zip Code: 60435	County: CHAMPAIGN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PRESENCE ST. JOSEPH MEDICAL CENTER	140007	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	PRESENCE PSYCH	14S007	16974	4	01/01/2013	N	P	P	4.00
5.00	Subprovider - IRF	SJMC PHYSICAL MED & REHAB	14T007	16974	5	09/07/1987	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2015	12/31/2015	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 §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	10,395	5,774	0	0	1,970	1,769	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.	116	42	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2016 11:45 am

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			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)	Y			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2016 11:45 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2016 11:45 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2016 11:45 am

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

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	15,419,686	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
	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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2016 11:45 am

		1.00	2.00	
	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	148003	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: PRESENCE HEALTH	Contractor's Name: NGS	Contractor's Number: 00450	141.00
142.00	Street: 200 SOUTH WACKER DRIVE	PO Box:		142.00
143.00	City: CHICAGO	State: IL	Zip Code: 60606	143.00

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

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

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

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

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

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

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

		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)	10/01/2013	09/30/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140007	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/27/2016 11:45 am

		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: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2016 11:45 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	06/30/2015	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	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)		N		N	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)		Y	04/30/2016	Y	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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/27/2016 11:45 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
			Y/N	Date		
			1.00	2.00		
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					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.	ROBERT	LEPPERT			41.00
42.00	Enter the employer/company name of the cost report preparer.	PRESENCE HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630/914-2396	ROBERT.LEPPERT@PRESENCEHEALTH.ORG			43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/27/2016 11:45 am

		Part B Date 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)				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)	04/30/2016			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.				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.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			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.		SENIOR REIMBURSEMENT ANALYST		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

HFS Supplemental Information | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part IX | Date/Time Prepared: 5/27/2016 11:45 am

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00
	RHC			
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/27/2016 11:45 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	349	127,385	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)		349	127,385	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	34	12,410	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	18	6,570	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		401	146,365	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	31	11,315		0	16.00
17.00	SUBPROVIDER - IRF	41.00	41	14,965		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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)		473				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: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2016 11:45 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	39,937	3,509	68,800			1.00
2.00	HMO and other (see instructions)	9,433	11,042				2.00
3.00	HMO IPF Subprovider	0	2,393				3.00
4.00	HMO IRF Subprovider	818	42				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	39,937	3,509	68,800			7.00
8.00	INTENSIVE CARE UNIT	3,105	210	7,757			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	2,688	60	6,290			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1,255	4,000			13.00
14.00	Total (see instructions)	45,730	5,034	86,847	0.46	1,828.81	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	1,439	7,222	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	7,704	116	10,842	0.00	52.12	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)				0.46	1,880.93	27.00
28.00	Observation Bed Days		724	11,988			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: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/27/2016 11:45 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	9,202	1,426	19,840	1.00
2.00	HMO and other (see instructions)			1,951	2,687		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				16		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	9,202	1,426	19,840	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	283	1,555	16.00
17.00	SUBPROVIDER - IRF	0.00	0	631	2	879	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: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/27/2016 11:45 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	130,139,738	-217,465	129,922,273	3,912,333.00	33.21	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	61,577	61,577	874.00	70.45	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		10,253,603	332,701	10,586,304	192,669.00	54.95	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		5,015,020	61,577	5,076,597	172,121.00	29.49	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		1,112,769	0	1,112,769	10,018.00	111.08	13.00
14.00	Home office salaries & wage-related costs		22,389,100	0	22,389,100	415,708.00	53.86	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)		30,956,167	0	30,956,167			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,690,348	0	1,690,348			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	343,808	-217,465	126,343	0.00	0.00	26.00
27.00	Administrative & General	5.00	10,677,382	0	10,677,382	339,239.00	31.47	27.00
28.00	Administrative & General under contract (see inst.)		165,207	0	165,207	2,236.00	73.89	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,724,386	0	2,724,386	99,027.00	27.51	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	2,505,391	0	2,505,391	163,367.00	15.34	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,628,522	-1,495,257	1,133,265	71,794.00	15.78	34.00
35.00	Dietary under contract (see instructions)		520,096	0	520,096	28,062.00	18.53	35.00
36.00	Cafeteria	11.00	0	1,495,257	1,495,257	96,964.00	15.42	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	4,659,399	0	4,659,399	113,595.00	41.02	38.00
39.00	Central Services and Supply	14.00	881,780	0	881,780	46,381.00	19.01	39.00
40.00	Pharmacy	15.00	4,113,726	-332,701	3,781,025	95,797.00	39.47	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/27/2016 11:45 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	2,215,029	0	2,215,029	88,054.00	25.16	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part III Date/Time Prepared: 5/27/2016 11:45 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		130,825,041	-279,042	130,545,999	3,941,757.00	33.12	1.00
2.00	Excluded area salaries (see instructions)		10,253,603	332,701	10,586,304	192,669.00	54.95	2.00
3.00	Subtotal salaries (line 1 minus line 2)		120,571,438	-611,743	119,959,695	3,749,088.00	32.00	3.00
4.00	Subtotal other wages & related costs (see inst.)		28,516,889	61,577	28,578,466	597,847.00	47.80	4.00
5.00	Subtotal wage-related costs (see inst.)		30,956,167	0	30,956,167	0.00	25.81	5.00
6.00	Total (sum of lines 3 thru 5)		180,044,494	-550,166	179,494,328	4,346,935.00	41.29	6.00
7.00	Total overhead cost (see instructions)		31,434,726	-550,166	30,884,560	1,144,516.00	26.98	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 5/27/2016 11:45 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	4,378,013	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	4,314,516	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	11,170,876	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	287,140	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	60,093	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)	512,502	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,723,838	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	9,237,332	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	365,033	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))	217,465	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	379,706	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	32,646,514	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part V | Date/Time Prepared: 5/27/2016 11:45 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	8,105,804	0	1.00
2.00	Hospital	8,092,059	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	13,745	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-10 | Date/Time Prepared: 5/27/2016 11:45 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.183362	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	27,714,577	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	335,995,514	6.00
7.00	Medicaid cost (line 1 times line 6)	61,608,809	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)	33,894,232	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)	33,894,232	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	36,311,489	6,387,372	42,698,861	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	6,658,147	1,171,201	7,829,348	21.00
22.00	Partial payment by patients approved for charity care	239,175	1,171,201	1,410,376	22.00
23.00	Cost of charity care (line 21 minus line 22)	6,418,972	0	6,418,972	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)	31,107,087	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	1,685,397	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	29,421,690	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	5,394,820	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	11,813,792	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	45,708,024	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/27/2016 11:45 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		16,228,843	16,228,843	8,054,326	24,283,169	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	8,401,970	8,401,970	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	343,808	25,616,184	25,959,992	-228,989	25,731,003	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,677,382	79,160,459	89,837,841	-883,969	88,953,872	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,724,386	12,523,225	15,247,611	-1,983,393	13,264,218	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,137,949	1,137,949	-286	1,137,663	8.00
9.00	00900	HOUSEKEEPING	2,505,391	1,204,677	3,710,068	-53,746	3,656,322	9.00
10.00	01000	DIETARY	2,628,522	3,670,864	6,299,386	-3,619,328	2,680,058	10.00
11.00	01100	CAFETERIA	0	0	0	3,555,315	3,555,315	11.00
13.00	01300	NURSING ADMINISTRATION	4,659,399	745,264	5,404,663	-90,852	5,313,811	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	881,780	3,934,440	4,816,220	-2,816,766	1,999,454	14.00
15.00	01500	PHARMACY	4,113,726	18,227,829	22,341,555	-908,987	21,432,568	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,215,029	1,813,170	4,028,199	-6,484	4,021,715	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	61,577	61,577	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	331,138	26,916	358,054	332,641	690,695	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,432,247	4,401,695	38,833,942	-8,496,236	30,337,706	30.00
31.00	03100	INTENSIVE CARE UNIT	6,358,137	854,240	7,212,377	-523,802	6,688,575	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,385,726	642,369	5,028,095	-440,813	4,587,282	34.00
40.00	04000	SUBPROVIDER - IPF	2,932,415	1,689,452	4,621,867	-18,587	4,603,280	40.00
41.00	04100	SUBPROVIDER - IRF	3,171,461	318,428	3,489,889	-109,186	3,380,703	41.00
43.00	04300	NURSERY	1,375,019	158,326	1,533,345	-64,386	1,468,959	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,311,455	36,474,246	46,785,701	-28,391,850	18,393,851	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,547,445	8,912,190	18,459,635	-3,740,493	14,719,142	54.00
60.00	06000	LABORATORY	0	13,780,192	13,780,192	-279,830	13,500,362	60.00
65.00	06500	RESPIRATORY THERAPY	2,349,085	765,733	3,114,818	-616,124	2,498,694	65.00
66.00	06600	PHYSICAL THERAPY	7,895,512	2,880,301	10,775,813	-311,758	10,464,055	66.00
69.00	06900	ELECTROCARDIOLOGY	3,788,060	8,722,198	12,510,258	-8,317,591	4,192,667	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	360,992	47,971	408,963	-33,378	375,585	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	26,382,274	26,382,274	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,075,010	19,075,010	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	553,610	55,164	608,774	6,667,663	7,276,437	76.00
76.10	03550	OUTPATIENT PSYCH	323,216	9,265	332,481	-1,076	331,405	76.10
76.97	07697	CARDIAC REHABILITATION	530,746	22,082	552,828	-4,650	548,178	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,925,462	1,939,909	8,865,371	-666,342	8,199,029	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		9,665,393	9,665,393	-9,665,393	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	126,321,149	255,628,974	381,950,123	256,481	382,206,604	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	3,818,589	10,678,432	14,497,021	-256,481	14,240,540	192.01
200.00		TOTAL (SUM OF LINES 118-199)	130,139,738	266,307,406	396,447,144	0	396,447,144	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/27/2016 11:45 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-3,503,585	20,779,584		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-44,696	8,357,274		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,053,859	30,784,862		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,818,734	79,135,138		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	-81,643	13,182,575		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	187,251	1,324,914		8.00
9.00	00900	HOUSEKEEPING	0	3,656,322		9.00
10.00	01000	DIETARY	-1,811,513	868,545		10.00
11.00	01100	CAFETERIA	0	3,555,315		11.00
13.00	01300	NURSING ADMINISTRATION	-82,295	5,231,516		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,108,434	3,107,888		14.00
15.00	01500	PHARMACY	-278,844	21,153,724		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-20,460	4,001,255		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	61,577		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	690,695		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-51,905	30,285,801		30.00
31.00	03100	INTENSIVE CARE UNIT	1,183,129	7,871,704		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	4,587,282		34.00
40.00	04000	SUBPROVIDER - IPF	-1,545,229	3,058,051		40.00
41.00	04100	SUBPROVIDER - IRF	0	3,380,703		41.00
43.00	04300	NURSERY	0	1,468,959		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-860,288	17,533,563		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,297,084	13,422,058		54.00
60.00	06000	LABORATORY	35,750	13,536,112		60.00
65.00	06500	RESPIRATORY THERAPY	12,500	2,511,194		65.00
66.00	06600	PHYSICAL THERAPY	-22,195	10,441,860		66.00
69.00	06900	ELECTROCARDIOLOGY	-113,773	4,078,894		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	375,585		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	26,382,274		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,075,010		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	OTHER ANCILLARY	0	7,276,437		76.00
76.10	03550	OUTPATIENT PSYCH	0	331,405		76.10
76.97	07697	CARDIAC REHABILITATION	-27,881	520,297		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-17,704	8,181,325		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)	-11,996,906	370,209,698		118.00
		NONREIMBURSABLE COST CENTERS				
192.01	19201	OTHER NRCC	0	14,240,540		192.01
200.00		TOTAL (SUM OF LINES 118-199)	-11,996,906	384,450,238		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet Non-CMS W | Date/Time Prepared: 5/27/2016 11:45 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	02100		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	02200		22.00
23.00	PARAMED ED PRGM-(SPECIFY)	02300		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
34.00	SURGICAL INTENSIVE CARE UNIT	03400		34.00
40.00	SUBPROVIDER - IPF	04000		40.00
41.00	SUBPROVIDER - IRF	04100		41.00
43.00	NURSERY	04300		43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	OTHER ANCILLARY	03950		76.00
76.10	OUTPATIENT PSYCH	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.10
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
	OUTPATIENT SERVICE COST CENTERS			
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
192.01	OTHER NRCC	19201		192.01
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/27/2016 11:45 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	1,495,257	2,060,058		1.00
	0		1,495,257	2,060,058		
	B - RECLASS CAPITAL INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	195,028		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	75,503		2.00
	0		0	270,531		
	C - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,665,393		1.00
	0		0	9,665,393		
	D - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	26,382,274		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	19,075,010		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
	0		0	45,457,284		
	E - RECLASS MOVABLE EQ DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,326,467		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
	0		0	8,326,467		

RECLASSIFICATIONS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/27/2016 11:45 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	F - RECLASS IV THERAPY					
1.00	OTHER ANCILLARY	76.00	5,745,307	936,594		1.00
	0		5,745,307	936,594		
	G - RECLASS PHARMARCIST TEACHING					
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	332,701	0		1.00
	0		332,701	0		
	H - RECLASS RESIDENT COSTS					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	61,577		1.00
	0		0	61,577		
	I - RECLASS BENEFIT DOLLARS TO NONWAGE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	217,465		1.00
	0		0	217,465		
500.00	Grand Total: Increases		7,573,265	66,995,369		500.00

RECLASSIFICATIONS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/27/2016 11:45 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	1,495,257	2,060,058	0		1.00
	0		1,495,257	2,060,058			
	B - RECLASS CAPITAL INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	195,028	12		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	75,503	12		2.00
	0		0	270,531			
	C - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	9,665,393	11		1.00
	0		0	9,665,393			
	D - RECLASS MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9,304	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	18,936	0		2.00
3.00	OPERATION OF PLANT	7.00	0	14,557	0		3.00
4.00	HOUSEKEEPING	9.00	0	28,067	0		4.00
5.00	DIETARY	10.00	0	17,655	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	15,358	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,787,446	0		7.00
8.00	PHARMACY	15.00	0	569,693	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	50	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	1,578,881	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	458,890	0		11.00
12.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	391,040	0		12.00
13.00	SUBPROVIDER - IRF	41.00	0	94,510	0		13.00
14.00	NURSERY	43.00	0	59,235	0		14.00
15.00	OPERATING ROOM	50.00	0	26,777,567	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,019,520	0		16.00
17.00	LABORATORY	60.00	0	63,975	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	598,193	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	265,274	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	8,056,227	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	22,335	0		21.00
22.00	OTHER ANCILLARY	76.00	0	13,301	0		22.00
23.00	OUTPATIENT PSYCH	76.10	0	710	0		23.00
24.00	CARDIAC REHABILITATION	76.97	0	1,868	0		24.00
25.00	EMERGENCY	91.00	0	586,537	0		25.00
26.00	OTHER NRCC	192.01	0	1,001	0		26.00
27.00	SUBPROVIDER - IPF	40.00	0	7,154	0		27.00
	0		0	45,457,284			
	E - RECLASS MOVABLE EQ DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,806,095	9		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,220	9		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	750,390	9		3.00
4.00	OPERATION OF PLANT	7.00	0	1,968,836	9		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	286	9		5.00
6.00	HOUSEKEEPING	9.00	0	25,679	9		6.00
7.00	DIETARY	10.00	0	46,358	9		7.00
8.00	NURSING ADMINISTRATION	13.00	0	75,494	9		8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	29,320	9		9.00
10.00	PHARMACY	15.00	0	6,593	9		10.00
11.00	MEDICAL RECORDS & LIBRARY	16.00	0	6,434	9		11.00
12.00	PARAMED ED PRGM-(SPECIFY)	23.00	0	60	9		12.00
13.00	ADULTS & PEDIATRICS	30.00	0	235,454	9		13.00
14.00	INTENSIVE CARE UNIT	31.00	0	64,912	9		14.00
15.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	49,773	9		15.00
16.00	SUBPROVIDER - IRF	41.00	0	14,676	9		16.00
17.00	NURSERY	43.00	0	5,151	9		17.00
18.00	OPERATING ROOM	50.00	0	1,614,283	9		18.00
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	720,973	9		19.00
20.00	LABORATORY	60.00	0	215,855	9		20.00
21.00	RESPIRATORY THERAPY	65.00	0	17,931	9		21.00
22.00	PHYSICAL THERAPY	66.00	0	46,484	9		22.00
23.00	ELECTROCARDIOLOGY	69.00	0	261,364	9		23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	11,043	9		24.00
25.00	OTHER ANCILLARY	76.00	0	937	9		25.00
26.00	OUTPATIENT PSYCH	76.10	0	366	9		26.00
27.00	CARDIAC REHABILITATION	76.97	0	2,782	9		27.00
28.00	EMERGENCY	91.00	0	79,805	9		28.00
29.00	OTHER NRCC	192.01	0	255,480	9		29.00
30.00	SUBPROVIDER - IPF	40.00	0	11,433	0		30.00
	0		0	8,326,467			

RECLASSIFICATIONS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/27/2016 11:45 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	F - RECLASS IV THERAPY						
1.00	ADULTS & PEDIATRICS	30.00	5,745,307	936,594	0		1.00
	0		5,745,307	936,594			
	G - RECLASS PHARMARCIST TEACHING						
1.00	PHARMACY	15.00	332,701	0	0		1.00
	0		332,701	0			
	H - RECLASS RESIDENT COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	61,577	0		1.00
	0		0	61,577			
	I - RECLASS BENEFIT DOLLARS TO NONWAGE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	217,465	0	0		1.00
	0		217,465	0			
500.00	Grand Total: Decreases		7,790,730	66,777,904			500.00

RECLASSIFICATIONS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 5/27/2016 11:45 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - RECLASS CAFETERIA COSTS								
1.00	CAFETERIA	11.00	1,495,257	2,060,058	DIETARY	10.00	1,495,257	2,060,058	1.00
	0		1,495,257	2,060,058	0		1,495,257	2,060,058	
	B - RECLASS CAPITAL INSURANCE								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	195,028	ADMINISTRATIVE & GENERAL	5.00	0	195,028	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	75,503	ADMINISTRATIVE & GENERAL	5.00	0	75,503	2.00
	0		0	270,531	0		0	270,531	
	C - RECLASS INTEREST EXPENSE								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,665,393	INTEREST EXPENSE	113.00	0	9,665,393	1.00
	0		0	9,665,393	0		0	9,665,393	
	D - RECLASS MEDICAL SUPPLIES								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	26,382,274	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9,304	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	19,075,010	ADMINISTRATIVE & GENERAL	5.00	0	18,936	2.00
3.00		0.00	0	0	OPERATION OF PLANT	7.00	0	14,557	3.00
4.00		0.00	0	0	HOUSEKEEPING	9.00	0	28,067	4.00
5.00		0.00	0	0	DIETARY	10.00	0	17,655	5.00
6.00		0.00	0	0	NURSING ADMINISTRATION	13.00	0	15,358	6.00
7.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	2,787,446	7.00
8.00		0.00	0	0	PHARMACY	15.00	0	569,693	8.00
9.00		0.00	0	0	MEDICAL RECORDS & LIBRARY	16.00	0	50	9.00
10.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	1,578,881	10.00
11.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	458,890	11.00
12.00		0.00	0	0	SURGICAL INTENSIVE CARE UNIT	34.00	0	391,040	12.00
13.00		0.00	0	0	SUBPROVIDER - IRF	41.00	0	94,510	13.00
14.00		0.00	0	0	NURSERY	43.00	0	59,235	14.00
15.00		0.00	0	0	OPERATING ROOM	50.00	0	26,777,567	15.00
16.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	3,019,520	16.00
17.00		0.00	0	0	LABORATORY	60.00	0	63,975	17.00
18.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	598,193	18.00
19.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	265,274	19.00
20.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	8,056,227	20.00
21.00		0.00	0	0	ELECTROENCEPHALOGRAPHY	70.00	0	22,335	21.00
22.00		0.00	0	0	OTHER ANCILLARY	76.00	0	13,301	22.00
23.00		0.00	0	0	OUTPATIENT PSYCH	76.10	0	710	23.00
24.00		0.00	0	0	CARDIAC REHABILITATION	76.97	0	1,868	24.00
25.00		0.00	0	0	EMERGENCY	91.00	0	586,537	25.00
26.00		0.00	0	0	OTHER NRCC	192.01	0	1,001	26.00
27.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	7,154	27.00
	0		0	45,457,284	0		0	45,457,284	
	E - RECLASS MOVABLE EQ DEPRECIATION								
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,326,467	CAP REL COSTS-BLDG & FIXT	1.00	0	1,806,095	1.00
2.00		0.00	0	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,220	2.00
3.00		0.00	0	0	ADMINISTRATIVE & GENERAL	5.00	0	750,390	3.00
4.00		0.00	0	0	OPERATION OF PLANT	7.00	0	1,968,836	4.00
5.00		0.00	0	0	LAUNDRY & LINEN SERVICE	8.00	0	286	5.00
6.00		0.00	0	0	HOUSEKEEPING	9.00	0	25,679	6.00
7.00		0.00	0	0	DIETARY	10.00	0	46,358	7.00
8.00		0.00	0	0	NURSING ADMINISTRATION	13.00	0	75,494	8.00
9.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	29,320	9.00
10.00		0.00	0	0	PHARMACY	15.00	0	6,593	10.00
11.00		0.00	0	0	MEDICAL RECORDS & LIBRARY	16.00	0	6,434	11.00
12.00		0.00	0	0	PARAMED ED PRGM-(SPECIFY)	23.00	0	60	12.00
13.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	235,454	13.00
14.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	64,912	14.00
15.00		0.00	0	0	SURGICAL INTENSIVE CARE UNIT	34.00	0	49,773	15.00

RECLASSIFICATIONS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 5/27/2016 11:45 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
16.00		0.00	0	0	SUBPROVIDER - IRF	41.00	0	14,676	16.00
17.00		0.00	0	0	NURSERY	43.00	0	5,151	17.00
18.00		0.00	0	0	OPERATING ROOM	50.00	0	1,614,283	18.00
19.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	720,973	19.00
20.00		0.00	0	0	LABORATORY	60.00	0	215,855	20.00
21.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	17,931	21.00
22.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	46,484	22.00
23.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	261,364	23.00
24.00		0.00	0	0	ELECTROENCEPHALOGRAPHY	70.00	0	11,043	24.00
25.00		0.00	0	0	OTHER ANCILLARY	76.00	0	937	25.00
26.00		0.00	0	0	OUTPATIENT PSYCH	76.10	0	366	26.00
27.00		0.00	0	0	CARDIAC REHABILITATION	76.97	0	2,782	27.00
28.00		0.00	0	0	EMERGENCY	91.00	0	79,805	28.00
29.00		0.00	0	0	OTHER NRCC	192.01	0	255,480	29.00
30.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	11,433	30.00
	0		0	8,326,467	0		0	8,326,467	
	F - RECLASS IV THERAPY								
1.00	OTHER ANCILLARY	76.00	5,745,307	936,594	ADULTS & PEDIATRICS	30.00	5,745,307	936,594	1.00
	0		5,745,307	936,594	0		5,745,307	936,594	
	G - RECLASS PHARMARCIST TEACHING								
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	332,701	0	PHARMACY	15.00	332,701	0	1.00
	0		332,701	0	0		332,701	0	
	H - RECLASS RESIDENT COSTS								
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	61,577	ADMINISTRATIVE & GENERAL	5.00	0	61,577	1.00
	0		0	61,577	0		0	61,577	
	I - RECLASS BENEFIT DOLLARS TO NONWAGE								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	217,465	EMPLOYEE BENEFITS DEPARTMENT	4.00	217,465	0	1.00
	0		0	217,465	0		217,465	0	
500.00	Grand Total: Increases		7,573,265	66,995,369	Grand Total: Decreases		7,790,730	66,777,904	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/27/2016 11:45 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,884,595	0	0	0	0	1.00
2.00	Land Improvements	1,957,490	0	0	0	0	2.00
3.00	Buildings and Fixtures	335,132,954	4,542,094	0	4,542,094	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	127,169,566	6,845,305	0	6,845,305	3,432,216	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	466,144,605	11,387,399	0	11,387,399	3,432,216	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	466,144,605	11,387,399	0	11,387,399	3,432,216	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,884,595	0	1.00
2.00	Land Improvements	1,957,490	0	2.00
3.00	Buildings and Fixtures	339,675,048	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	130,582,655	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	474,099,788	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	474,099,788	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/27/2016 11:45 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	16,228,843	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)	16,228,843	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	16,228,843	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	16,228,843	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/27/2016 11:45 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	343,517,134	0	343,517,134	0.724567	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	130,582,655	0	130,582,655	0.275433	0	2.00
3.00	Total (sum of lines 1-2)	474,099,789	0	474,099,789	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	14,959,140	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	8,281,771	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	23,240,911	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	5,625,416	195,028	0	0	20,779,584	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	75,503	0	0	8,357,274	2.00
3.00	Total (sum of lines 1-2)	5,625,416	270,531	0	0	29,136,858	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/27/2016 11:45 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,770,916			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	133,246			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-82	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
34.00	MISC INCOME	B	-2,806,128	ADMINISTRATIVE & GENERAL	5.00	0	34.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/27/2016 11:45 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
35.00	MISC INCOME	B	-81,643	OPERATION OF PLANT	7.00	0	35.00
36.00	MISC INCOME	B	-1,811,513	DIETARY	10.00	0	36.00
37.00	MISC INCOME	B	-45,595	NURSING ADMINISTRATION	13.00	0	37.00
38.00	MISC INCOME	B	-233,598	PHARMACY	15.00	0	38.00
39.00	MISC INCOME	B	-20,460	MEDICAL RECORDS & LIBRARY	16.00	0	39.00
40.00	MISC INCOME	B	-5,012	ADULTS & PEDIATRICS	30.00	0	40.00
41.00	INTEREST INCOME HOME OFFICE	B	-4,039,977	CAP REL COSTS-BLDG & FIXT	1.00	11	41.00
42.00	MISC INCOME	B	-10,870	RADIOLOGY-DIAGNOSTIC	54.00	0	42.00
43.00	MISC INCOME	B	-2,162	LABORATORY	60.00	0	43.00
44.00	MISC INCOME	B	-22,195	PHYSICAL THERAPY	66.00	0	44.00
44.01	MISC INCOME	B	-9,093	ELECTROCARDIOLOGY	69.00	0	44.01
44.02	MISC INCOME	B	-27,881	CARDIAC REHABILITATION	76.97	0	44.02
44.03	MISC INCOME	B	-1,525	EMERGENCY	91.00	0	44.03
44.04	MISC INCOME	B	-24,840	SUBPROVIDER - IPF	40.00	0	44.04
45.00	PENSION ADJUST TO AVERAGE	A	4,041,292	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.00
46.00	MARKETING OFFSET	A	-2,421	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.01	NRCC DEPR EXPENSE	A	-44,696	CAP REL COSTS-MVBLE EQUIP	2.00	9	47.01
48.00	PATIENT TRANSPORTATION	A	-210,837	ADMINISTRATIVE & GENERAL	5.00	0	48.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,996,906				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: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 5/27/2016 11:45 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DEPRECIATION	536,392	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	1,012,649	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	ADMINSTRATION	33,374,903	38,969,126	3.00
3.01	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	187,251	0	3.01
3.02	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICES	1,108,434	0	3.02
3.03	31.00	INTENSIVE CARE UNIT	ICU	1,229,293	0	3.03
3.04	50.00	OPERATING ROOM	SURGERY	1,577,038	0	3.04
4.00	60.00	LABORATORY	LAB	11,573,196	11,496,784	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			50,599,156	50,465,910	5.00

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

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

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

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

6.00	B	PRESENCE HEALTH	100.00		0.00	6.00
7.00			0.00		0.00	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: 140007	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-1 Date/Time Prepared: 5/27/2016 11:45 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	536,392	9		1.00
2.00	1,012,649	0		2.00
3.00	-5,594,223	0		3.00
3.01	187,251	0		3.01
3.02	1,108,434	0		3.02
3.03	1,229,293	0		3.03
3.04	1,577,038	0		3.04
4.00	76,412	0		4.00
5.00	133,246			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			6.00
7.00			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: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/27/2016 11:45 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,245,696	1,195,271	50,425	211,500	399	1.00
2.00	13.00	NURSING ADMINISTRATION	36,700	36,700	0	0	0	2.00
3.00	15.00	PHARMACY	47,585	41,846	5,739	211,500	23	3.00
4.00	30.00	ADULTS & PEDIATRICS	467,656	16,357	451,298	211,500	4,138	4.00
5.00	31.00	INTENSIVE CARE UNIT	65,585	27,322	38,263	211,500	191	5.00
6.00	41.00	SUBPROVIDER - IRF	75,833	0	75,833	211,500	1,040	6.00
7.00	50.00	OPERATING ROOM	2,442,918	2,431,918	11,000	211,500	55	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	1,286,214	1,286,214	0	0	0	8.00
9.00	60.00	LABORATORY	38,500	38,500	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	30,000	-12,500	42,500	211,500	425	10.00
11.00	69.00	ELECTROCARDIOLOGY	181,876	47,751	134,125	197,500	813	11.00
12.00	91.00	EMERGENCY	343,098	16,179	326,919	246,400	3,470	12.00
13.00	40.00	SUBPROVIDER - IPF	1,571,637	1,519,137	52,500	211,500	504	13.00
200.00			7,833,298	6,644,695	1,188,602		11,058	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	40,571	2,029	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	15.00	PHARMACY	2,339	117	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	420,763	21,038	0	0	0	4.00
5.00	31.00	INTENSIVE CARE UNIT	19,421	971	0	0	0	5.00
6.00	41.00	SUBPROVIDER - IRF	105,750	5,288	0	0	0	6.00
7.00	50.00	OPERATING ROOM	5,592	280	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	0	0	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	43,215	2,161	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	77,196	3,860	0	0	0	11.00
12.00	91.00	EMERGENCY	411,061	20,553	0	0	0	12.00
13.00	40.00	SUBPROVIDER - IPF	51,248	2,562	0	0	0	13.00
200.00			1,177,156	58,859	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	40,571	9,854	1,205,125		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	36,700		2.00
3.00	15.00	PHARMACY	0	2,339	3,400	45,246		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	420,763	30,535	46,893		4.00
5.00	31.00	INTENSIVE CARE UNIT	0	19,421	18,842	46,164		5.00
6.00	41.00	SUBPROVIDER - IRF	0	105,750	0	0		6.00
7.00	50.00	OPERATING ROOM	0	5,592	5,408	2,437,326		7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,286,214		8.00
9.00	60.00	LABORATORY	0	0	0	38,500		9.00
10.00	65.00	RESPIRATORY THERAPY	0	43,215	0	-12,500		10.00
11.00	69.00	ELECTROCARDIOLOGY	0	77,196	56,929	104,680		11.00
12.00	91.00	EMERGENCY	0	411,061	0	16,179		12.00
13.00	40.00	SUBPROVIDER - IPF	0	51,248	1,252	1,520,389		13.00
200.00			0	1,177,156	126,220	6,770,916		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/27/2016 11:45 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	20,779,584	20,779,584				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	8,357,274		8,357,274			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	30,784,862	86,044	2,845	30,873,751		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	79,135,138	5,148,697	961,788	2,539,765	87,785,388	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	13,182,575	3,039,989	2,523,490	648,033	19,394,087	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,324,914	121,077	367	0	1,446,358	8.00
9.00	00900	HOUSEKEEPING	3,656,322	227,886	32,913	595,942	4,513,063	9.00
10.00	01000	DIETARY	868,545	186,146	59,418	269,563	1,383,672	10.00
11.00	01100	CAFETERIA	3,555,315	253,306	0	355,668	4,164,289	11.00
13.00	01300	NURSING ADMINISTRATION	5,231,516	109,545	96,762	1,108,303	6,546,126	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,107,888	438,198	37,580	209,744	3,793,410	14.00
15.00	01500	PHARMACY	21,153,724	59,541	8,450	899,370	22,121,085	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,001,255	201,782	8,247	526,876	4,738,160	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	61,577	0	0	0	61,577	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	690,695	4,560	77	157,903	853,235	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,285,801	4,565,218	301,786	6,823,563	41,976,368	30.00
31.00	03100	INTENSIVE CARE UNIT	7,871,704	520,195	83,199	1,512,372	9,987,470	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,587,282	412,759	63,795	1,043,206	6,107,042	34.00
40.00	04000	SUBPROVIDER - IPF	3,058,051	500,133	14,654	697,516	4,270,354	40.00
41.00	04100	SUBPROVIDER - IRF	3,380,703	324,777	18,810	754,376	4,478,666	41.00
43.00	04300	NURSERY	1,468,959	154,647	6,602	327,068	1,957,276	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,533,563	1,522,265	2,069,056	2,452,724	23,577,608	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,422,058	814,480	924,084	2,270,993	17,431,615	54.00
60.00	06000	LABORATORY	13,536,112	244,794	276,665	0	14,057,571	60.00
65.00	06500	RESPIRATORY THERAPY	2,511,194	41,758	22,982	558,763	3,134,697	65.00
66.00	06600	PHYSICAL THERAPY	10,441,860	156,927	59,579	1,878,058	12,536,424	66.00
69.00	06900	ELECTROCARDIOLOGY	4,078,894	327,133	334,995	901,043	5,642,065	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	375,585	85,892	14,154	85,867	561,498	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,382,274	0	0	0	26,382,274	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,075,010	0	0	0	19,075,010	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	7,276,437	79,736	1,201	1,498,286	8,855,660	76.00
76.10	03550	OUTPATIENT PSYCH	331,405	6,003	469	76,881	414,758	76.10
76.97	07697	CARDIAC REHABILITATION	520,297	112,451	3,566	126,245	762,559	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,181,325	600,805	102,288	1,647,318	10,531,736	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	370,209,698	20,346,744	8,029,822	29,965,446	368,541,101	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	14,240,540	432,840	327,452	908,305	15,909,137	192.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	384,450,238	20,779,584	8,357,274	30,873,751	384,450,238	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/27/2016 11:45 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	87,785,388					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	5,738,865	0	25,132,952			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	427,989	0	243,347	2,117,694		8.00
9.00	00900	HOUSEKEEPING	1,335,451	0	458,017	0	6,306,531	9.00
10.00	01000	DIETARY	409,440	0	374,127	0	96,573	10.00
11.00	01100	CAFETERIA	1,232,246	0	509,108	0	131,416	11.00
13.00	01300	NURSING ADMINISTRATION	1,937,051	0	220,169	0	56,832	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,122,500	0	880,714	0	227,339	14.00
15.00	01500	PHARMACY	6,545,806	0	119,669	0	30,890	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,402,059	0	405,552	0	104,685	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	18,221	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	252,479	0	9,164	0	2,366	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,421,030	0	9,175,431	1,388,770	2,368,457	30.00
31.00	03100	INTENSIVE CARE UNIT	2,955,372	0	1,045,517	156,580	269,879	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,807,123	0	829,586	126,968	214,141	34.00
40.00	04000	SUBPROVIDER - IPF	1,263,632	0	1,005,194	145,781	259,471	40.00
41.00	04100	SUBPROVIDER - IRF	1,325,273	0	652,756	218,853	168,496	41.00
43.00	04300	NURSERY	579,174	0	310,818	80,742	80,232	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,976,803	0	3,059,533	0	789,758	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,158,154	0	1,636,987	0	422,556	54.00
60.00	06000	LABORATORY	4,159,748	0	492,001	0	127,000	60.00
65.00	06500	RESPIRATORY THERAPY	927,582	0	83,928	0	21,664	65.00
66.00	06600	PHYSICAL THERAPY	3,709,628	0	315,400	0	81,414	66.00
69.00	06900	ELECTROCARDIOLOGY	1,669,532	0	657,491	0	169,718	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	166,152	0	172,630	0	44,561	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,806,726	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,644,448	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	2,620,461	0	160,258	0	41,368	76.00
76.10	03550	OUTPATIENT PSYCH	122,730	0	12,066	0	3,115	76.10
76.97	07697	CARDIAC REHABILITATION	225,647	0	226,011	0	58,340	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,116,425	0	1,207,531	0	311,700	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)	83,077,747	0	24,263,005	2,117,694	6,081,971	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	4,707,641	0	869,947	0	224,560	192.01
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)	87,785,388	0	25,132,952	2,117,694	6,306,531	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/27/2016 11:45 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	2,263,812					10.00
11.00	01100	CAFETERIA	0	6,037,059				11.00
13.00	01300	NURSING ADMINISTRATION	0	255,654	9,015,832			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	93,030	0	6,116,993		14.00
15.00	01500	PHARMACY	0	169,110	0	0	28,986,560	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	241,051	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,521,677	1,745,569	4,004,898	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	174,017	303,801	697,016	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	141,109	234,008	536,889	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	161,437	170,821	391,917	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	243,812	202,773	465,225	0	0	41.00
43.00	04300	NURSERY	0	53,717	123,244	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	467,698	1,073,048	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	505,101	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	149,971	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	354,971	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	169,428	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	22,840	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,264,476	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,852,517	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	28,986,560	73.00
76.00	03950	OTHER ANCILLARY	0	319,001	731,889	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	20,214	46,376	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	27,495	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	21,760	412,031	945,330	0	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)	2,263,812	5,918,284	9,015,832	6,116,993	28,986,560	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	0	118,775	0	0	0	192.01
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)	2,263,812	6,037,059	9,015,832	6,116,993	28,986,560	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/27/2016 11:45 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	
			16.00	17.00	21.00	22.00	23.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	6,891,507					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		79,798		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0			1,117,244	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	646,519	0	0	39,899	0	30.00
31.00	03100	INTENSIVE CARE UNIT	149,332	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	109,868	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	48,024	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	72,097	0	0	0	0	41.00
43.00	04300	NURSERY	26,453	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	606,102	0	0	39,899	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,309,897	0	0	0	0	54.00
60.00	06000	LABORATORY	888,651	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	150,395	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	222,310	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	449,828	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,773	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	525,335	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	401,139	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	563,046	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	154,465	0	0	0	1,117,244	76.00
76.10	03550	OUTPATIENT PSYCH	5,058	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	7,579	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	534,636	0	0	0	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)	6,891,507	0	0	79,798	1,117,244	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,891,507	0	0	79,798	1,117,244	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/27/2016 11:45 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
6.00	00600	MAINTENANCE & REPAIRS					6.00
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					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	75,288,618	-39,899	75,248,719		30.00
31.00	03100	INTENSIVE CARE UNIT	15,738,984	0	15,738,984		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	10,106,734	0	10,106,734		34.00
40.00	04000	SUBPROVIDER - IPF	7,716,631	0	7,716,631		40.00
41.00	04100	SUBPROVIDER - IRF	7,827,951	0	7,827,951		41.00
43.00	04300	NURSERY	3,211,656	0	3,211,656		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	36,590,449	-39,899	36,550,550		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,464,310	0	26,464,310		54.00
60.00	06000	LABORATORY	19,724,971	0	19,724,971		60.00
65.00	06500	RESPIRATORY THERAPY	4,468,237	0	4,468,237		65.00
66.00	06600	PHYSICAL THERAPY	17,220,147	0	17,220,147		66.00
69.00	06900	ELECTROCARDIOLOGY	8,758,062	0	8,758,062		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	988,454	0	988,454		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,978,811	0	36,978,811		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,973,114	0	28,973,114		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,549,606	0	29,549,606		73.00
76.00	03950	OTHER ANCILLARY	14,000,346	0	14,000,346		76.00
76.10	03550	OUTPATIENT PSYCH	624,317	0	624,317		76.10
76.97	07697	CARDIAC REHABILITATION	1,307,631	0	1,307,631		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	17,081,149	0	17,081,149		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	362,620,178	-79,798	362,540,380		118.00
		NONREIMBURSABLE COST CENTERS					
192.01	19201	OTHER NRCC	21,830,060	0	21,830,060		192.01
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)	384,450,238	-79,798	384,370,440		202.00

COST ALLOCATION STATISTICS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet Non-CMS W | Date/Time Prepared: 5/27/2016 11:45 am

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM COST	5.00
6.00	MAINTENANCE & REPAIRS	4	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	P	TOTAL PATIENT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	6	MEALS SERVED	10.00
11.00	CAFETERIA	7	MEALS SERVED	11.00
13.00	NURSING ADMINISTRATION	8	DIRECT NRSING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	9	COSTED REQUIS.	14.00
15.00	PHARMACY	10	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS REVENUE	16.00
17.00	SOCIAL SERVICE	11	TIME SPENT	17.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	12	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	13	ASSIGNED TIME	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	14	ASSIGNED TIME	23.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/27/2016 11:45 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	86,044	2,845	88,889	88,889	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	5,148,697	961,788	6,110,485	7,314	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	3,039,989	2,523,490	5,563,479	1,866	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	121,077	367	121,444	0	8.00
9.00	00900	HOUSEKEEPING	0	227,886	32,913	260,799	1,716	9.00
10.00	01000	DIETARY	0	186,146	59,418	245,564	776	10.00
11.00	01100	CAFETERIA	0	253,306	0	253,306	1,024	11.00
13.00	01300	NURSING ADMINISTRATION	0	109,545	96,762	206,307	3,192	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	438,198	37,580	475,778	604	14.00
15.00	01500	PHARMACY	0	59,541	8,450	67,991	2,590	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	201,782	8,247	210,029	1,517	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	4,560	77	4,637	455	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,565,218	301,786	4,867,004	19,631	30.00
31.00	03100	INTENSIVE CARE UNIT	0	520,195	83,199	603,394	4,355	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	412,759	63,795	476,554	3,004	34.00
40.00	04000	SUBPROVIDER - IPF	0	500,133	14,654	514,787	2,009	40.00
41.00	04100	SUBPROVIDER - IRF	0	324,777	18,810	343,587	2,172	41.00
43.00	04300	NURSERY	0	154,647	6,602	161,249	942	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,522,265	2,069,056	3,591,321	7,063	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	814,480	924,084	1,738,564	6,540	54.00
60.00	06000	LABORATORY	0	244,794	276,665	521,459	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	41,758	22,982	64,740	1,609	65.00
66.00	06600	PHYSICAL THERAPY	0	156,927	59,579	216,506	5,408	66.00
69.00	06900	ELECTROCARDIOLOGY	0	327,133	334,995	662,128	2,595	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	85,892	14,154	100,046	247	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
76.00	03950	OTHER ANCILLARY	0	79,736	1,201	80,937	4,315	76.00
76.10	03550	OUTPATIENT PSYCH	0	6,003	469	6,472	221	76.10
76.97	07697	CARDIAC REHABILITATION	0	112,451	3,566	116,017	364	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	600,805	102,288	703,093	4,744	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	20,346,744	8,029,822	28,376,566	86,273	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	0	432,840	327,452	760,292	2,616	192.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	20,779,584	8,357,274	29,136,858	88,889	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/27/2016 11:45 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,117,799					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	399,945	0	5,965,290			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,827	0	57,758	209,029		8.00
9.00	00900	HOUSEKEEPING	93,068	0	108,710	0	464,293	9.00
10.00	01000	DIETARY	28,534	0	88,799	0	7,110	10.00
11.00	01100	CAFETERIA	85,876	0	120,836	0	9,675	11.00
13.00	01300	NURSING ADMINISTRATION	134,994	0	52,257	0	4,184	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,228	0	209,037	0	16,737	14.00
15.00	01500	PHARMACY	456,181	0	28,403	0	2,274	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	97,710	0	96,258	0	7,707	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,270	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	17,595	0	2,175	0	174	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	865,616	0	2,177,783	137,081	174,367	30.00
31.00	03100	INTENSIVE CARE UNIT	205,962	0	248,153	15,455	19,869	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	125,939	0	196,902	12,532	15,765	34.00
40.00	04000	SUBPROVIDER - IPF	88,063	0	238,582	14,389	19,102	40.00
41.00	04100	SUBPROVIDER - IRF	92,359	0	154,931	21,602	12,405	41.00
43.00	04300	NURSERY	40,363	0	73,772	7,970	5,907	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	486,217	0	726,178	0	58,143	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	359,475	0	388,538	0	31,109	54.00
60.00	06000	LABORATORY	289,895	0	116,776	0	9,350	60.00
65.00	06500	RESPIRATORY THERAPY	64,644	0	19,920	0	1,595	65.00
66.00	06600	PHYSICAL THERAPY	258,526	0	74,860	0	5,994	66.00
69.00	06900	ELECTROCARDIOLOGY	116,351	0	156,055	0	12,495	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,579	0	40,974	0	3,281	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	544,055	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	393,365	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	182,621	0	38,037	0	3,046	76.00
76.10	03550	OUTPATIENT PSYCH	8,553	0	2,864	0	229	76.10
76.97	07697	CARDIAC REHABILITATION	15,725	0	53,644	0	4,295	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	217,185	0	286,607	0	22,948	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)	5,789,721	0	5,758,809	209,029	447,761	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	328,078	0	206,481	0	16,532	192.01
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)	6,117,799	0	5,965,290	209,029	464,293	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/27/2016 11:45 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	370,783					10.00
11.00	01100	CAFETERIA	0	470,717				11.00
13.00	01300	NURSING ADMINISTRATION	0	19,934	420,868			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,254	0	787,638		14.00
15.00	01500	PHARMACY	0	13,186	0	0	570,625	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,795	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	249,231	136,103	186,953	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	28,502	23,688	32,537	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	23,112	18,246	25,063	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	26,441	13,319	18,295	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	39,933	15,810	21,717	0	0	41.00
43.00	04300	NURSERY	0	4,188	5,753	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	36,467	50,091	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	39,383	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,693	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	27,678	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	13,211	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,781	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	291,577	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	496,061	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	570,625	73.00
76.00	03950	OTHER ANCILLARY	0	24,873	34,165	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	1,576	2,165	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	2,144	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,564	32,127	44,129	0	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)	370,783	461,456	420,868	787,638	570,625	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	0	9,261	0	0	0	192.01
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)	370,783	470,717	420,868	787,638	570,625	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/27/2016 11:45 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	
			16.00	17.00	21.00	22.00	23.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	432,016					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		1,270		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0			25,036	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,616	0				30.00
31.00	03100	INTENSIVE CARE UNIT	9,381	0				31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	6,902	0				34.00
40.00	04000	SUBPROVIDER - IPF	3,017	0				40.00
41.00	04100	SUBPROVIDER - IRF	4,529	0				41.00
43.00	04300	NURSERY	1,662	0				43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,077	0				50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,366	0				54.00
60.00	06000	LABORATORY	55,827	0				60.00
65.00	06500	RESPIRATORY THERAPY	9,448	0				65.00
66.00	06600	PHYSICAL THERAPY	13,966	0				66.00
69.00	06900	ELECTROCARDIOLOGY	28,259	0				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,305	0				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	33,003	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,201	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,372	0				73.00
76.00	03950	OTHER ANCILLARY	9,704	0				76.00
76.10	03550	OUTPATIENT PSYCH	318	0				76.10
76.97	07697	CARDIAC REHABILITATION	476	0				76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	33,587	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)	432,016	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	0	0				192.01
200.00		Cross Foot Adjustments			0	1,270	25,036	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	432,016	0	0	1,270	25,036	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/27/2016 11:45 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
6.00	00600	MAINTENANCE & REPAIRS					6.00
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					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	8,854,385	0	8,854,385		30.00
31.00	03100	INTENSIVE CARE UNIT	1,191,296	0	1,191,296		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	904,019	0	904,019		34.00
40.00	04000	SUBPROVIDER - IPF	938,004	0	938,004		40.00
41.00	04100	SUBPROVIDER - IRF	709,045	0	709,045		41.00
43.00	04300	NURSERY	301,806	0	301,806		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,993,557	0	4,993,557		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,644,975	0	2,644,975		54.00
60.00	06000	LABORATORY	993,307	0	993,307		60.00
65.00	06500	RESPIRATORY THERAPY	173,649	0	173,649		65.00
66.00	06600	PHYSICAL THERAPY	602,938	0	602,938		66.00
69.00	06900	ELECTROCARDIOLOGY	991,094	0	991,094		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	159,213	0	159,213		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	868,635	0	868,635		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	914,627	0	914,627		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	605,997	0	605,997		73.00
76.00	03950	OTHER ANCILLARY	377,698	0	377,698		76.00
76.10	03550	OUTPATIENT PSYCH	22,398	0	22,398		76.10
76.97	07697	CARDIAC REHABILITATION	192,665	0	192,665		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	1,347,984	0	1,347,984		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,787,292	0	27,787,292		118.00
		NONREIMBURSABLE COST CENTERS					
192.01	19201	OTHER NRCC	1,323,260	0	1,323,260		192.01
200.00		Cross Foot Adjustments	26,306	0	26,306		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	29,136,858	0	29,136,858		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/27/2016 11:45 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,093,755					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,520,371				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,529	2,220	129,795,930			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	271,007	750,390	10,677,382	-87,785,388	296,664,850	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	160,013	1,968,836	2,724,386	0	19,394,087	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,373	286	0	0	1,446,358	8.00
9.00	00900	HOUSEKEEPING	11,995	25,679	2,505,391	0	4,513,063	9.00
10.00	01000	DIETARY	9,798	46,358	1,133,265	0	1,383,672	10.00
11.00	01100	CAFETERIA	13,333	0	1,495,257	0	4,164,289	11.00
13.00	01300	NURSING ADMINISTRATION	5,766	75,494	4,659,399	0	6,546,126	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,065	29,320	881,780	0	3,793,410	14.00
15.00	01500	PHARMACY	3,134	6,593	3,781,025	0	22,121,085	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,621	6,434	2,215,029	0	4,738,160	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	61,577	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	240	60	663,839	0	853,235	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	240,295	235,454	28,686,940	0	41,976,368	30.00
31.00	03100	INTENSIVE CARE UNIT	27,381	64,912	6,358,137	0	9,987,470	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	21,726	49,773	4,385,726	0	6,107,042	34.00
40.00	04000	SUBPROVIDER - IPF	26,325	11,433	2,932,415	0	4,270,354	40.00
41.00	04100	SUBPROVIDER - IRF	17,095	14,676	3,171,461	0	4,478,666	41.00
43.00	04300	NURSERY	8,140	5,151	1,375,019	0	1,957,276	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	80,126	1,614,283	10,311,455	0	23,577,608	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,871	720,973	9,547,445	0	17,431,615	54.00
60.00	06000	LABORATORY	12,885	215,855	0	0	14,057,571	60.00
65.00	06500	RESPIRATORY THERAPY	2,198	17,931	2,349,085	0	3,134,697	65.00
66.00	06600	PHYSICAL THERAPY	8,260	46,484	7,895,512	0	12,536,424	66.00
69.00	06900	ELECTROCARDIOLOGY	17,219	261,364	3,788,060	0	5,642,065	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,521	11,043	360,992	0	561,498	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	26,382,274	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	19,075,010	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	4,197	937	6,298,917	0	8,855,660	76.00
76.10	03550	OUTPATIENT PSYCH	316	366	323,216	0	414,758	76.10
76.97	07697	CARDIAC REHABILITATION	5,919	2,782	530,746	0	762,559	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	31,624	79,805	6,925,462	0	10,531,736	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)	1,070,972	6,264,892	125,977,341	-87,785,388	280,755,713	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	22,783	255,479	3,818,589	0	15,909,137	192.01
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)	20,779,584	8,357,274	30,873,751		87,785,388	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.998390	1.281718	0.237864		0.295908	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			88,889		6,117,799	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000685		0.020622	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/27/2016 11:45 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	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						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	658,206				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,373	104,911			8.00
9.00	00900	HOUSEKEEPING	0	11,995	0	639,838		9.00
10.00	01000	DIETARY	0	9,798	0	9,798	434,765	10.00
11.00	01100	CAFETERIA	0	13,333	0	13,333	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,766	0	5,766	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,065	0	23,065	0	14.00
15.00	01500	PHARMACY	0	3,134	0	3,134	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,621	0	10,621	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	240	0	240	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	240,295	68,800	240,295	292,238	30.00
31.00	03100	INTENSIVE CARE UNIT	0	27,381	7,757	27,381	33,420	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	21,726	6,290	21,726	27,100	34.00
40.00	04000	SUBPROVIDER - IPF	0	26,325	7,222	26,325	31,004	40.00
41.00	04100	SUBPROVIDER - IRF	0	17,095	10,842	17,095	46,824	41.00
43.00	04300	NURSERY	0	8,140	4,000	8,140	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	80,126	0	80,126	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	42,871	0	42,871	0	54.00
60.00	06000	LABORATORY	0	12,885	0	12,885	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,198	0	2,198	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,260	0	8,260	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	17,219	0	17,219	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,521	0	4,521	0	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
76.00	03950	OTHER ANCILLARY	0	4,197	0	4,197	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	316	0	316	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	5,919	0	5,919	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	31,624	0	31,624	4,179	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)	0	635,423	104,911	617,055	434,765	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	0	22,783	0	22,783	0	192.01
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)	0	25,132,952	2,117,694	6,306,531	2,263,812	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	38.184021	20.185624	9.856450	5.206978	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	5,965,290	209,029	464,293	370,783	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	9.062953	1.992441	0.725641	0.852835	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/27/2016 11:45 am

		Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	151,721					11.00
13.00	01300	NURSING ADMINISTRATION	6,425	98,758				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,338	0	45,514,808			14.00
15.00	01500	PHARMACY	4,250	0	0	21,153,724		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,058	0	0	0	1,977,185,090	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,869	43,869	0	0	185,461,482	30.00
31.00	03100	INTENSIVE CARE UNIT	7,635	7,635	0	0	42,837,504	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,881	5,881	0	0	31,516,963	34.00
40.00	04000	SUBPROVIDER - IPF	4,293	4,293	0	0	13,776,341	40.00
41.00	04100	SUBPROVIDER - IRF	5,096	5,096	0	0	20,681,881	41.00
43.00	04300	NURSERY	1,350	1,350	0	0	7,588,284	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,754	11,754	0	0	173,867,577	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,694	0	0	0	376,034,834	54.00
60.00	06000	LABORATORY	0	0	0	0	254,919,927	60.00
65.00	06500	RESPIRATORY THERAPY	3,769	0	0	0	43,142,565	65.00
66.00	06600	PHYSICAL THERAPY	8,921	0	0	0	63,772,144	66.00
69.00	06900	ELECTROCARDIOLOGY	4,258	0	0	0	129,038,339	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	574	0	0	0	5,959,064	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	16,849,279	0	150,698,632	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	28,665,529	0	115,071,298	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,153,724	161,516,295	73.00
76.00	03950	OTHER ANCILLARY	8,017	8,017	0	0	44,310,205	76.00
76.10	03550	OUTPATIENT PSYCH	508	508	0	0	1,450,851	76.10
76.97	07697	CARDIAC REHABILITATION	691	0	0	0	2,174,257	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,355	10,355	0	0	153,366,647	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)	148,736	98,758	45,514,808	21,153,724	1,977,185,090	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	2,985	0	0	0	0	192.01
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)	6,037,059	9,015,832	6,116,993	28,986,560	6,891,507	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.790530	91.292169	0.134396	1.370282	0.003486	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	470,717	420,868	787,638	570,625	432,016	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.102517	4.261609	0.017305	0.026975	0.000219	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/27/2016 11:45 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)		
			17.00	21.00	22.00	23.00		
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	0					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		100			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0			100		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	50	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0		34.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	50	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
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
76.00	03950	OTHER ANCILLARY	0	0	0	100		76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0		76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	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)	0	0	100	100		118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	0	0	0	0		192.01
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)	0	0	79,798	1,117,244		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	797.980000	11,172.440000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	1,270	25,036		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	12.700000	250.360000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	75,248,719		75,248,719	30,535	75,279,254	30.00
31.00	03100	INTENSIVE CARE UNIT	15,738,984		15,738,984	18,842	15,757,826	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	10,106,734		10,106,734	0	10,106,734	34.00
40.00	04000	SUBPROVIDER - IPF	7,716,631		7,716,631	1,252	7,717,883	40.00
41.00	04100	SUBPROVIDER - IRF	7,827,951		7,827,951	0	7,827,951	41.00
43.00	04300	NURSERY	3,211,656		3,211,656	0	3,211,656	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,550,550		36,550,550	5,408	36,555,958	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,464,310		26,464,310	0	26,464,310	54.00
60.00	06000	LABORATORY	19,724,971		19,724,971	0	19,724,971	60.00
65.00	06500	RESPIRATORY THERAPY	4,468,237	0	4,468,237	0	4,468,237	65.00
66.00	06600	PHYSICAL THERAPY	17,220,147	0	17,220,147	0	17,220,147	66.00
69.00	06900	ELECTROCARDIOLOGY	8,758,062		8,758,062	56,929	8,814,991	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	988,454		988,454	0	988,454	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,978,811		36,978,811	0	36,978,811	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,973,114		28,973,114	0	28,973,114	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,549,606		29,549,606	0	29,549,606	73.00
76.00	03950	OTHER ANCILLARY	14,000,346		14,000,346	0	14,000,346	76.00
76.10	03550	OUTPATIENT PSYCH	624,317		624,317	0	624,317	76.10
76.97	07697	CARDIAC REHABILITATION	1,307,631		1,307,631	0	1,307,631	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	17,081,149		17,081,149	0	17,081,149	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,170,538		11,170,538		11,170,538	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	373,710,918	0	373,710,918	112,966	373,823,884	200.00
201.00		Less Observation Beds	11,170,538		11,170,538		11,170,538	201.00
202.00		Total (see instructions)	362,540,380	0	362,540,380	112,966	362,653,346	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	163,283,562		163,283,562			30.00
31.00	03100	INTENSIVE CARE UNIT	42,837,504		42,837,504			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	31,516,963		31,516,963			34.00
40.00	04000	SUBPROVIDER - IPF	13,776,341		13,776,341			40.00
41.00	04100	SUBPROVIDER - IRF	20,681,881		20,681,881			41.00
43.00	04300	NURSERY	7,588,284		7,588,284			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	74,887,362	98,980,215	173,867,577	0.210221	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	127,990,691	248,044,143	376,034,834	0.070377	0.000000	54.00
60.00	06000	LABORATORY	130,061,914	124,858,013	254,919,927	0.077377	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	38,754,016	4,388,549	43,142,565	0.103569	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	32,007,599	31,764,545	63,772,144	0.270026	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	53,008,748	76,029,591	129,038,339	0.067872	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,045,082	3,913,982	5,959,064	0.165874	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	90,175,108	60,523,524	150,698,632	0.245383	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	75,378,542	39,692,756	115,071,298	0.251784	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	123,512,674	38,003,621	161,516,295	0.182951	0.000000	73.00
76.00	03950	OTHER ANCILLARY	3,449,303	40,860,902	44,310,205	0.315962	0.000000	76.00
76.10	03550	OUTPATIENT PSYCH	836,898	613,953	1,450,851	0.430311	0.000000	76.10
76.97	07697	CARDIAC REHABILITATION	11,282	2,162,975	2,174,257	0.601415	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	53,358,373	100,008,274	153,366,647	0.111375	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,396,073	16,781,847	22,177,920	0.503678	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	1,090,558,200	886,626,890	1,977,185,090			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,090,558,200	886,626,890	1,977,185,090			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.210252	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.070377	54.00
60.00	06000	LABORATORY	0.077377	60.00
65.00	06500	RESPIRATORY THERAPY	0.103569	65.00
66.00	06600	PHYSICAL THERAPY	0.270026	66.00
69.00	06900	ELECTROCARDIOLOGY	0.068313	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165874	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.245383	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.251784	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.182951	73.00
76.00	03950	OTHER ANCILLARY	0.315962	76.00
76.10	03550	OUTPATIENT PSYCH	0.430311	76.10
76.97	07697	CARDIAC REHABILITATION	0.601415	76.97
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.111375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.503678	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: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	8,854,385	0	8,854,385	80,788	109.60	30.00
31.00	INTENSIVE CARE UNIT	1,191,296		1,191,296	7,757	153.58	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	904,019		904,019	6,290	143.72	34.00
40.00	SUBPROVIDER - IPF	938,004	0	938,004	7,222	129.88	40.00
41.00	SUBPROVIDER - IRF	709,045	0	709,045	10,842	65.40	41.00
43.00	NURSERY	301,806		301,806	4,000	75.45	43.00
200.00	Total (lines 30-199)	12,898,555		12,898,555	116,899		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	39,937	4,377,095	30.00
31.00	INTENSIVE CARE UNIT	3,105	476,866	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	2,688	386,319	34.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	7,704	503,842	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	53,434	5,744,122	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,993,557	173,867,577	0.028720	29,932,674	859,666	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,644,975	376,034,834	0.007034	68,440,901	481,413	54.00
60.00	06000	LABORATORY	993,307	254,919,927	0.003897	65,732,786	256,161	60.00
65.00	06500	RESPIRATORY THERAPY	173,649	43,142,565	0.004025	20,379,460	82,027	65.00
66.00	06600	PHYSICAL THERAPY	602,938	63,772,144	0.009455	9,739,826	92,090	66.00
69.00	06900	ELECTROCARDIOLOGY	991,094	129,038,339	0.007681	31,374,472	240,987	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	159,213	5,959,064	0.026718	923,013	24,661	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	868,635	150,698,632	0.005764	40,957,955	236,082	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	914,627	115,071,298	0.007948	32,693,948	259,851	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	605,997	161,516,295	0.003752	59,744,690	224,162	73.00
76.00	03950	OTHER ANCILLARY	377,698	44,310,205	0.008524	1,531,826	13,057	76.00
76.10	03550	OUTPATIENT PSYCH	22,398	1,450,851	0.015438	188,940	2,917	76.10
76.97	07697	CARDIAC REHABILITATION	192,665	2,174,257	0.088612	2,917	258	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,347,984	153,366,647	0.008789	26,068,210	229,113	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,313,890	22,177,920	0.059243	2,764,193	163,759	92.00
200.00		Total (lines 50-199)	16,202,627	1,697,500,555		390,475,811	3,166,204	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0		0	34.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	80,788	0.00	39,937	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,757	0.00	3,105	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	6,290	0.00	2,688	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	7,222	0.00	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	10,842	0.00	7,704	0	0	41.00
43.00	04300	NURSERY	4,000	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	116,899		53,434	0	0	200.00

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
			12.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0		34.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
43.00	04300	NURSERY	0	0		43.00
200.00		Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
76.00	03950	OTHER ANCILLARY	0	0	1,117,244	0	1,117,244	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	1,117,244	0	1,117,244	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	173,867,577	0.000000	0.000000	29,932,674	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	376,034,834	0.000000	0.000000	68,440,901	54.00
60.00	06000	LABORATORY	0	254,919,927	0.000000	0.000000	65,732,786	60.00
65.00	06500	RESPIRATORY THERAPY	0	43,142,565	0.000000	0.000000	20,379,460	65.00
66.00	06600	PHYSICAL THERAPY	0	63,772,144	0.000000	0.000000	9,739,826	66.00
69.00	06900	ELECTROCARDIOLOGY	0	129,038,339	0.000000	0.000000	31,374,472	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,959,064	0.000000	0.000000	923,013	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	150,698,632	0.000000	0.000000	40,957,955	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	115,071,298	0.000000	0.000000	32,693,948	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	161,516,295	0.000000	0.000000	59,744,690	73.00
76.00	03950	OTHER ANCILLARY	1,117,244	44,310,205	0.025214	0.025214	1,531,826	76.00
76.10	03550	OUTPATIENT PSYCH	0	1,450,851	0.000000	0.000000	188,940	76.10
76.97	07697	CARDIAC REHABILITATION	0	2,174,257	0.000000	0.000000	2,917	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	153,366,647	0.000000	0.000000	26,068,210	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	22,177,920	0.000000	0.000000	2,764,193	92.00
200.00		Total (lines 50-199)	1,117,244	1,697,500,555			390,475,811	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	26,253,677	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	55,907,572	0	0	0	54.00
60.00	06000	LABORATORY	0	17,483,249	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,055,960	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,809,367	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	27,519,870	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	974,224	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,036,729	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,502,712	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,735,359	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	38,623	13,780,656	347,465	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	1,089,096	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	15,857,720	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,341,311	0	0	0	92.00
200.00		Total (lines 50-199)	38,623	214,347,502	347,465	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
			23.00	24.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
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	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.210221	26,253,677	17	984	5,519,074	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.070377	55,907,572	14,537	0	3,934,607	54.00
60.00	06000	LABORATORY	0.077377	17,483,249	1,209	0	1,352,801	60.00
65.00	06500	RESPIRATORY THERAPY	0.103569	1,055,960	0	0	109,365	65.00
66.00	06600	PHYSICAL THERAPY	0.270026	2,809,367	0	492	758,602	66.00
69.00	06900	ELECTROCARDIOLOGY	0.067872	27,519,870	0	0	1,867,829	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165874	974,224	0	0	161,598	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.245383	20,036,729	0	0	4,916,673	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.251784	14,502,712	0	0	3,651,551	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.182951	11,735,359	0	47,731	2,146,996	73.00
76.00	03950	OTHER ANCILLARY	0.315962	13,780,656	0	0	4,354,164	76.00
76.10	03550	OUTPATIENT PSYCH	0.430311	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.601415	1,089,096	0	0	654,999	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.111375	15,857,720	0	0	1,766,154	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.503678	5,341,311	0	0	2,690,301	92.00
200.00		Subtotal (see instructions)		214,347,502	15,763	49,207	33,884,714	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		214,347,502	15,763	49,207	33,884,714	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	4	207		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,023	0		54.00
60.00	06000	LABORATORY	94	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	133		66.00
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	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,732		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.10	03550	OUTPATIENT PSYCH	0	0		76.10
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	1,121	9,072		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,121	9,072		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140007 | Component CCN: 14S007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,993,557	173,867,577	0.028720	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,644,975	376,034,834	0.007034	0	0	54.00
60.00	06000	LABORATORY	993,307	254,919,927	0.003897	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	173,649	43,142,565	0.004025	0	0	65.00
66.00	06600	PHYSICAL THERAPY	602,938	63,772,144	0.009455	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	991,094	129,038,339	0.007681	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	159,213	5,959,064	0.026718	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	868,635	150,698,632	0.005764	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	914,627	115,071,298	0.007948	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	605,997	161,516,295	0.003752	0	0	73.00
76.00	03950	OTHER ANCILLARY	377,698	44,310,205	0.008524	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	22,398	1,450,851	0.015438	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	192,665	2,174,257	0.088612	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,347,984	153,366,647	0.008789	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	22,177,920	0.000000	0	0	92.00
200.00		Total (lines 50-199)	14,888,737	1,697,500,555		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Component CCN: 14S007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
76.00	03950	OTHER ANCILLARY	0	0	1,117,244	0	1,117,244	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	1,117,244	0	1,117,244	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Component CCN: 14S007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	173,867,577	0.000000	0.000000	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	376,034,834	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	254,919,927	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	43,142,565	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	63,772,144	0.000000	0.000000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	129,038,339	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,959,064	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	150,698,632	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	115,071,298	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	161,516,295	0.000000	0.000000	0	73.00
76.00	03950	OTHER ANCILLARY	1,117,244	44,310,205	0.025214	0.025214	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	1,450,851	0.000000	0.000000	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	2,174,257	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	153,366,647	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	22,177,920	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	1,117,244	1,697,500,555			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Component CCN: 14S007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Component CCN: 14S007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.10	03550	OUTPATIENT PSYCH	0	0		76.10
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,993,557	173,867,577	0.028720	28,121	808	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,644,975	376,034,834	0.007034	1,217,057	8,561	54.00
60.00	06000	LABORATORY	993,307	254,919,927	0.003897	3,191,778	12,438	60.00
65.00	06500	RESPIRATORY THERAPY	173,649	43,142,565	0.004025	870,631	3,504	65.00
66.00	06600	PHYSICAL THERAPY	602,938	63,772,144	0.009455	11,101,123	104,961	66.00
69.00	06900	ELECTROCARDIOLOGY	991,094	129,038,339	0.007681	108,927	837	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	159,213	5,959,064	0.026718	19,242	514	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	868,635	150,698,632	0.005764	750,357	4,325	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	914,627	115,071,298	0.007948	14,440	115	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	605,997	161,516,295	0.003752	3,647,059	13,684	73.00
76.00	03950	OTHER ANCILLARY	377,698	44,310,205	0.008524	22,789	194	76.00
76.10	03550	OUTPATIENT PSYCH	22,398	1,450,851	0.015438	3,677	57	76.10
76.97	07697	CARDIAC REHABILITATION	192,665	2,174,257	0.088612	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,347,984	153,366,647	0.008789	32,979	290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	22,177,920	0.000000	40,421	0	92.00
200.00		Total (lines 50-199)	14,888,737	1,697,500,555		21,048,601	150,288	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
76.00	03950	OTHER ANCILLARY	0	0	1,117,244	0	1,117,244	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	1,117,244	0	1,117,244	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	173,867,577	0.000000	0.000000	28,121	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	376,034,834	0.000000	0.000000	1,217,057	54.00
60.00	06000	LABORATORY	0	254,919,927	0.000000	0.000000	3,191,778	60.00
65.00	06500	RESPIRATORY THERAPY	0	43,142,565	0.000000	0.000000	870,631	65.00
66.00	06600	PHYSICAL THERAPY	0	63,772,144	0.000000	0.000000	11,101,123	66.00
69.00	06900	ELECTROCARDIOLOGY	0	129,038,339	0.000000	0.000000	108,927	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,959,064	0.000000	0.000000	19,242	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	150,698,632	0.000000	0.000000	750,357	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	115,071,298	0.000000	0.000000	14,440	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	161,516,295	0.000000	0.000000	3,647,059	73.00
76.00	03950	OTHER ANCILLARY	1,117,244	44,310,205	0.025214	0.025214	22,789	76.00
76.10	03550	OUTPATIENT PSYCH	0	1,450,851	0.000000	0.000000	3,677	76.10
76.97	07697	CARDIAC REHABILITATION	0	2,174,257	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	153,366,647	0.000000	0.000000	32,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	22,177,920	0.000000	0.000000	40,421	92.00
200.00		Total (lines 50-199)	1,117,244	1,697,500,555			21,048,601	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
76.00	03950	OTHER ANCILLARY	575	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	575	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.10	03550	OUTPATIENT PSYCH	0	0		76.10
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.210221	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.070377	0	0	0	0	54.00
60.00	06000	LABORATORY	0.077377	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.103569	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.270026	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.067872	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165874	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.245383	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.251784	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.182951	0	0	2,246	0	73.00
76.00	03950	OTHER ANCILLARY	0.315962	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0.430311	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.601415	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.111375	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.503678	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	2,246	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	2,246	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	411		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.10	03550	OUTPATIENT PSYCH	0	0		76.10
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	411		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	411		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	80,788	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	80,788	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)	68,800	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)	39,937	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)	75,279,254	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)	75,279,254	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)	75,279,254	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)	931.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	37,213,696	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)	37,213,696	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	15,757,826	7,757	2,031.43	3,105	6,307,590	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	10,106,734	6,290	1,606.79	2,688	4,319,052	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)	57,308,566	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	105,148,904	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)	5,240,280	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,204,827	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	8,445,107	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	96,703,797	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)	11,988	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	931.81	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	11,170,538	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	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	8,854,385	75,279,254	0.117621	11,170,538	1,313,890	90.00
91.00	Nursing School cost	0	75,279,254	0.000000	11,170,538	0	91.00
92.00	Allied health cost	0	75,279,254	0.000000	11,170,538	0	92.00
93.00	All other Medical Education	0	75,279,254	0.000000	11,170,538	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140007 Component CCN: 14S007	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/27/2016 11:45 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,222	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,222	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)	7,222	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)	0	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)	7,717,883	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)	7,717,883	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)	7,717,883	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)	1,068.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140007 | Component CCN: 14S007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	0	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1

Component CCN: 14S007 | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	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	938,004	7,717,883	0.121536	0	0	90.00
91.00	Nursing School cost	0	7,717,883	0.000000	0	0	91.00
92.00	Allied health cost	0	7,717,883	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,717,883	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140007 Component CCN: 14T007	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/27/2016 11:45 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,842	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,842	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)	10,842	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)	7,704	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)	7,827,951	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)	7,827,951	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)	7,827,951	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)	722.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,562,288	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)	5,562,288	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1

Component CCN: 14T007 | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,324,738	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	9,887,026	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)	503,842	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	150,863	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	654,705	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	9,232,321	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1

Component CCN: 14T007 | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	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	709,045	7,827,951	0.090579	0	0	90.00
91.00	Nursing School cost	0	7,827,951	0.000000	0	0	91.00
92.00	Allied health cost	0	7,827,951	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,827,951	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		76,754,734		30.00
31.00	03100	INTENSIVE CARE UNIT		20,620,036		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		16,803,601		34.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.210252	29,932,674	6,293,405	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.070377	68,440,901	4,816,665	54.00
60.00	06000	LABORATORY	0.077377	65,732,786	5,086,206	60.00
65.00	06500	RESPIRATORY THERAPY	0.103569	20,379,460	2,110,680	65.00
66.00	06600	PHYSICAL THERAPY	0.270026	9,739,826	2,630,006	66.00
69.00	06900	ELECTROCARDIOLOGY	0.068313	31,374,472	2,143,284	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165874	923,013	153,104	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.245383	40,957,955	10,050,386	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.251784	32,693,948	8,231,813	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.182951	59,744,690	10,930,351	73.00
76.00	03950	OTHER ANCILLARY	0.315962	1,531,826	483,999	76.00
76.10	03550	OUTPATIENT PSYCH	0.430311	188,940	81,303	76.10
76.97	07697	CARDIAC REHABILITATION	0.601415	2,917	1,754	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.111375	26,068,210	2,903,347	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.503678	2,764,193	1,392,263	92.00
200.00		Total (sum of lines 50-94 and 96-98)		390,475,811	57,308,566	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)		390,475,811		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0		34.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		14,853,881		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.210252	28,121	5,912	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.070377	1,217,057	85,653	54.00
60.00	06000	LABORATORY	0.077377	3,191,778	246,970	60.00
65.00	06500	RESPIRATORY THERAPY	0.103569	870,631	90,170	65.00
66.00	06600	PHYSICAL THERAPY	0.270026	11,101,123	2,997,592	66.00
69.00	06900	ELECTROCARDIOLOGY	0.068313	108,927	7,441	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165874	19,242	3,192	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.245383	750,357	184,125	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.251784	14,440	3,636	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.182951	3,647,059	667,233	73.00
76.00	03950	OTHER ANCILLARY	0.315962	22,789	7,200	76.00
76.10	03550	OUTPATIENT PSYCH	0.430311	3,677	1,582	76.10
76.97	07697	CARDIAC REHABILITATION	0.601415	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.111375	32,979	3,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.503678	40,421	20,359	92.00
200.00		Total (sum of lines 50-94 and 96-98)		21,048,601	4,324,738	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)		21,048,601		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

		0	1.00	2.00	
	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)		59,821,753		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		19,940,584		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)		1,669,010		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		16,303,043		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		368.16		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		9.00		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)		5.85		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)		5.85		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)		9.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.46		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)		0.46		12.00
13.00	Total allowable FTE count for the prior year.		1.00		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.		0.94		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.80		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		0.80		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.002173		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.002568		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.002173		21.00
22.00	IME payment adjustment (see instructions)		94,678		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		19,352		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)		-8.54		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)		94,678		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		19,352		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.97		30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.92		31.00
32.00	Sum of lines 30 and 31		26.89		32.00
33.00	Allowable disproportionate share percentage (see instructions)		9.95		33.00
34.00	Disproportionate share adjustment (see instructions)		1,984,088		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		3,819,984	3,208,144	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		2,857,138	806,418	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		3,663,556		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		87,173,669		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		87,193,021		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		6,976,211		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).		7,627		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		17,881		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		38,623		58.00
59.00	Total (sum of amounts on lines 49 through 58)		94,233,363		59.00
60.00	Primary payer payments		30,416		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		94,202,947		61.00
62.00	Deductibles billed to program beneficiaries		7,570,120		62.00
63.00	Coinsurance billed to program beneficiaries		352,631		63.00
64.00	Allowable bad debts (see instructions)		1,510,151		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		981,598		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,423,796		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		87,261,794		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	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)		54,042		70.93
70.94	HRR adjustment amount (see instructions)		-2,147,912		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
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)		85,167,924		71.00
71.01	Sequestration adjustment (see instructions)		1,703,358		71.01
72.00	Interim payments		82,744,537		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)		720,029		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		172,043		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet DSH | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE						
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	3.97	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	22.92	0.00			22.92	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	26.89	0.00			22.92	3.00
4.00	Provider Type * (urban, rural,SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	368.16	0.00			368.16	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	9.95	0.00			8.12	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	3.97	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	1.29	0.00	0.00	0.00	0.00	14.00
	CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS						
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	10,395	0			10,395	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	5,774	0			5,774	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	1,970	0			1,970	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	1,769	0			1,769	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	19,908	0			19,908	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	86,847	0			86,847	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	86,847	0			86,847	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	22.92	0.00			22.92	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet DSH | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	11.40		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		11.40		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		11.40		0.00		31.00

		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	DETERMINATION OF PROVIDER TYPE						
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE	Provider CCN: 140007	Period: From 01/01/2015 To 12/31/2015	Worksheet DSH Date/Time Prepared: 5/27/2016 11:45 am
	Title XVIII	Hospital	PPS

		Revised Percentage 6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	8.12		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00		29.00
30.00	Line 28 or 29 as applicable	8.12		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	8.12		31.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/27/2016 11:45 am

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	59,821,753	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	19,940,584	0	0	0	0	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	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	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,669,010	0	0	0	0	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	16,303,043	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.002173	0.002173	0.002173	0.002173		5.00
6.00	IME payment adjustment (see instructions)	22.00	94,678	0	94,678	0	94,678	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	19,352	0	19,352	0	19,352	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	94,678	0	94,678	0	94,678	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	19,352	0	19,352	0	19,352	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0995	0.0995	0.0995	0.0995		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,984,088	0	1,984,088	0	1,984,088	11.00
11.01	Uncompensated care payments	36.00	3,663,556	0	2,857,138	806,418	3,663,556	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	87,173,669	0	86,367,251	806,418	87,173,669	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	87,193,021	0	86,386,603	806,418	87,193,021	15.00
16.00	Payment for inpatient program capital	50.00	6,976,211	0	6,976,211	0	6,976,211	16.00
17.00	Special add-on payments for new technologies	54.00	17,881	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/27/2016 11:45 am

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	93,362,814	806,418	94,169,232	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	6,382,778	0	0	0	0	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	229,614	0	0	0	0	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	0.0010	0.0010	0.0010	0.0010		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	6,383	0	6,383	0	6,383	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0560	0.0560	0.0560	0.0560		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	357,436	0	357,436	0	357,436	25.00
26.00	Total prospective capital payments (see instructions)	12.00	6,976,211	0	6,976,211	0	6,976,211	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.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	59,821,753	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	19,940,584		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,669,010	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	16,303,043	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.002173	0.002173	0.002173		5.00
6.00	IME payment adjustment (see instructions)	22.00	94,678	94,678	0	94,678	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	19,352	19,352	0	19,352	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	94,678	94,678	0	94,678	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	19,352	19,352	0	19,352	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0995	0.0995	0.0995		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,984,088	1,984,088	0	1,984,088	11.00
11.01	Uncompensated care payments	36.00	3,663,556	2,857,138	806,418	3,663,556	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	87,173,669	86,367,251	806,418	87,173,669	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	87,193,021	86,386,603	806,418	87,193,021	15.00
16.00	Payment for inpatient program capital	50.00	6,976,211	5,217,823	1,758,388	6,976,211	16.00
17.00	Special add-on payments for new technologies	54.00	17,881	13,374	4,507	17,881	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			91,617,800	2,569,313	94,187,113	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/27/2016 11:45 am

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	6,382,778	4,773,967	1,608,811	6,382,778	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	229,614	171,739	57,875	229,614	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	0.0010	0.0010	0.0010		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	6,383	4,774	1,609	6,383	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0560	0.0560	0.0560		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	357,436	267,343	90,093	357,436	25.00
26.00	Total prospective capital payments (see instructions)	12.00	6,976,211	5,217,823	1,758,388	6,976,211	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	54,042	40,420	13,622	54,042	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	-2,147,912	-1,606,520	-541,392	-2,147,912	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: 140007	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/27/2016 11:45 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	10,193	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	33,537,249	2.00
3.00	PPS payments	29,779,902	3.00
4.00	Outlier payment (see instructions)	78,533	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	347,465	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	10,193	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	64,970	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)	64,970	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	64,970	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	54,777	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)	10,193	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)	30,205,900	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	2,854	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	5,683,189	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)	24,530,050	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	2,247	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)	24,532,297	30.00
31.00	Primary payer payments	10,269	31.00
32.00	Subtotal (line 30 minus line 31)	24,522,028	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)	1,079,683	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	701,794	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,044,381	36.00
37.00	Subtotal (see instructions)	25,223,822	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-128	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)	25,223,950	40.00
40.01	Sequestration adjustment (see instructions)	504,479	40.01
41.00	Interim payments	23,670,456	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	1,049,015	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
		Overrides 1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140007 Component CCN: 14T007	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/27/2016 11:45 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	411	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	598	3.00
4.00	Outlier payment (see instructions)	0	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)	411	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,246	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)	2,246	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	2,246	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,835	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)	411	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)	598	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	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)	1,009	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)	1,009	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,009	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,009	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,009	40.00
40.01	Sequestration adjustment (see instructions)	20	40.01
41.00	Interim payments	932	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	57	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
		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		82,323,326		23,685,186	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/21/2015	421,211		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	07/21/2015	14,730	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)		421,211		-14,730	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)		82,744,537		23,670,456	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		720,029		1,049,015	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		83,464,566		24,719,471	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,965,701		932	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	07/21/2015	5,174		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)		-5,174		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)		10,960,527		932	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		57	6.01
6.02	SETTLEMENT TO PROGRAM		47,308		0	6.02
7.00	Total Medicare program liability (see instructions)		10,913,219		989	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: 140007	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/27/2016 11:45 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	19,840	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	45,730	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	9,433	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	82,847	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	1,977,185,090	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	42,698,861	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)	1,952,423	8.00
9.00	Sequestration adjustment amount (see instructions)	39,048	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,913,375	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1,784,069	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)	129,306	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140007 Component CCN: 14S007	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part II Date/Time Prepared: 5/27/2016 11:45 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	0	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	19.786301	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	0	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	0	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	0	18.00
19.00	Deductibles	0	19.00
20.00	Subtotal (line 18 minus line 19)	0	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	0	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	0	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	0	31.00
31.01	Sequestration adjustment (see instructions)	0	31.01
32.00	Interim payments	0	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140007 Component CCN: 14T007	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part III Date/Time Prepared: 5/27/2016 11:45 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	11,017,693	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0129	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	94,752	3.00
4.00	Outlier Payments	112,534	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	29.704110	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	11,224,979	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	11,224,979	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	11,224,979	19.00
20.00	Deductibles	46,576	20.00
21.00	Subtotal (line 19 minus line 20)	11,178,403	21.00
22.00	Coinsurance	45,045	22.00
23.00	Subtotal (line 21 minus line 22)	11,133,358	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	3,084	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	2,005	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,084	26.00
27.00	Subtotal (sum of lines 23 and 25)	11,135,363	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	575	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	11,135,938	32.00
32.01	Sequestration adjustment (see instructions)	222,719	32.01
33.00	Interim payments	10,960,527	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	-47,308	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	50,741	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	112,534	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-4 | Date/Time Prepared: 5/27/2016 11:45 am

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			9.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			5.85	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			5.85	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			9.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.46	6.00
7.00	Enter the lesser of line 5 or line 6			0.46	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.42	0.42	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.42	0.42	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	0.00	0.42		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.14		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	0.00	0.14		17.00
18.00	Per resident amount	114,366.00	114,366.00		18.00
19.00	Approved amount for resident costs	0	16,011	16,011	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			16,011	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	53,434	10,251		26.00
27.00	Total Inpatient Days (see instructions)	100,911	100,911		27.00
28.00	Ratio of inpatient days to total inpatient days	0.529516	0.101585		28.00
29.00	Program direct GME amount	8,478	1,626		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		230		30.00
31.00	Net Program direct GME amount			9,874	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 140007	Period: From 01/01/2015 To 12/31/2015	Worksheet E-4 Date/Time Prepared: 5/27/2016 11:45 am
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	115,035,930	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	30,416	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	115,005,514	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	33,895,318	42.00
43.00	Primary payer payments (see instructions)	10,269	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	33,885,049	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	148,890,563	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.772416	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.227584	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	9,874	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	7,627	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	2,247	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/27/2016 11:45 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6,346,000	0	0	0	1.00
2.00	Temporary investments	1,513,000	0	0	0	2.00
3.00	Notes receivable	83,000	0	0	0	3.00
4.00	Accounts receivable	53,568,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	9,594,000	0	0	0	6.00
7.00	Inventory	9,186,000	0	0	0	7.00
8.00	Prepaid expenses	893,000	0	0	0	8.00
9.00	Other current assets	1,634,000	0	0	0	9.00
10.00	Due from other funds	2,120,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	84,937,000	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	212,300,000	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	212,300,000	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,332,000	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	1,289,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,621,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	299,858,000	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	11,148,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	272,000	0	0	0	40.00
41.00	Deferred income	-24,000	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	54,307,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	65,703,000	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	757,000	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	3,236,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	3,993,000	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	69,696,000	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	230,162,000				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)	230,162,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	299,858,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/27/2016 11:45 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		245,331,471		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-40,235,774				2.00
3.00	Total (sum of line 1 and line 2)		205,095,697		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	OTHER UNRESTRICTED NET ASSETS	25,066,303		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		25,066,303		0		10.00
11.00	Subtotal (line 3 plus line 10)		230,162,000		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		230,162,000		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	OTHER UNRESTRICTED NET ASSETS		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			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: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/27/2016 11:45 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	182,267,421		182,267,421	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	20,680,980		20,680,980	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)	202,948,401		202,948,401	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	42,818,663		42,818,663	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	31,509,132		31,509,132	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	74,327,795		74,327,795	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	277,276,196		277,276,196	17.00
18.00	Ancillary services	809,913,980	890,012,098	1,699,926,078	18.00
19.00	Outpatient services	0	12,051,758	12,051,758	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,087,190,176	902,063,856	1,989,254,032	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		396,447,144		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		396,447,144		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140007 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-3 | Date/Time Prepared: 5/27/2016 11:45 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,989,254,032	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,640,038,187	2.00
3.00	Net patient revenues (line 1 minus line 2)	349,215,845	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	396,447,144	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-47,231,299	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	ALL OTHERS	6,078,010	24.00
24.01	OTHER GAINS	917,515	24.01
25.00	Total other income (sum of lines 6-24)	6,995,525	25.00
26.00	Total (line 5 plus line 25)	-40,235,774	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-40,235,774	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140007	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/27/2016 11:45 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	6,382,778	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	229,614	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)	226.98	3.00
4.00	Number of interns & residents (see instructions)	0.80	4.00
5.00	Indirect medical education percentage (see instructions)	0.10	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)	6,383	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	3.97	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	22.92	8.00
9.00	Sum of lines 7 and 8	26.89	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.60	10.00
11.00	Disproportionate share adjustment (see instructions)	357,436	11.00
12.00	Total prospective capital payments (see instructions)	6,976,211	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