

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: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/25/2016 1:32 pm
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/25/2016 Time: 1:32 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ADVOCATE TRINITY HOSPITAL ( 140048 ) 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 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	945,660	395,077	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
200.00 Total	0	945,660	395,077	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 140048		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 1:28 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 2320 E. 93RD ST.			PO Box:				1.00		
2.00	City: CHICAGO			State: IL		Zip Code: 60617-		County: COOK		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital			ADVOCATE TRINITY HOSPITAL	140048	16974	1	07/01/1966	N P O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						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)						N	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							3	N	23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			4,006	798	11	4	9,100	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0		25.00

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		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	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
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

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		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		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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	
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<u>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.</u>							
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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
				1.00		
<b>Long Term Care Hospital PPS</b>						
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
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N		87.00
				V	XIX	
				1.00	2.00	
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V		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
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N					105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N					106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N					108.00
		Physical		Speech		Respiratory	
		1.00		3.00		4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.					N	
						1.00	
						2.00	
						3.00	
<b>Miscellaneous Cost Reporting Information</b>							
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.	0					118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	637,752		2,395,202		4,220,746	
						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			
119.00	DO NOT USE THIS LINE						
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	
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			
<b>Transplant Center Information</b>							
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			
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.						
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.						
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.						
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.						
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.						
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.						
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.						
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.						
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.						

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 1:28 pm		
		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	148036	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: ADVOCATE HEALTHCARE	Contractor's Name: NATIONAL GOVT SERV		Contractor's Number: 00131		
142.00	Street: 3075 HIGHLAND PARKWAY SUITE 600	PO Box:				
143.00	City: DOWNERS GROVE	State: IL	Zip Code: 60515	143.00		
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?	Y		144.00		
				1.00 2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00		
				1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00		
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	
156.00	Subprovider - IPF	N	N	N	N	
157.00	Subprovider - IRF	N	N	N	N	
158.00	SUBPROVIDER					
159.00	SNF	N	N	N	N	
160.00	HOME HEALTH AGENCY	N	N	N	N	
161.00	CMHC		N	N	N	
161.10	CORF		N	N	N	
				1.00		
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00		
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
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	0.00
				1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y		167.00		
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0		168.00		
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01		
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99		169.00		
				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)	01/01/2015		12/31/2015		170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 1:28 pm
			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: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/25/2016 1:28 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/04/2016	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			Y	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	03/29/2016	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: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/25/2016 1:28 pm
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	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.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	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			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	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.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	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.			N	35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			Y	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			Y	40.00
				1.00	2.00
<b>Cost Report Preparer Contact Information</b>					
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.	SCOTT		MI TCHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVOCATE HEALTH CARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-929-5761		SCOTT.MI TCHELL@ADVOCATEHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/25/2016 1:28 pm
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		Part B		
		Date		
		4.00		
<b>PS&amp;R Data</b>				
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)	03/29/2016		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	
<b>Cost Report Preparer Contact Information</b>				
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.		SR. REIMBURSEMENT SPECIALIST	41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/25/2016 1:28 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	164	59,860	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)		164	59,860	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	27	9,855	0.00	0	8.00
9.00 CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	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)		191	69,715	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	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
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		191				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: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/25/2016 1:28 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,667	8,662	29,435			1.00
2.00 HMO and other (see instructions)	6,833	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	9,667	8,662	29,435			7.00
8.00 INTENSIVE CARE UNIT	2,534	2,165	7,358			8.00
9.00 CORONARY CARE UNIT	0	0	0			9.00
10.00 BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00 SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		2,782	2,995			13.00
14.00 Total (see instructions)	12,201	13,609	39,788	0.00	808.00	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	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
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	808.00	27.00
28.00 Observation Bed Days		637	5,524			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	310	341			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: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/25/2016 1:28 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,565	3,108	9,282	1.00
2.00	HMO and other (see instructions)			1,675	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,565	3,108	9,282	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	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
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part II Date/Time Prepared: 5/25/2016 1:28 pm			
	Worksheet A Line Number	Amount Reported	Reclassifi- cation 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		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	53,595,138	0	53,595,138	1,680,640.00	31.89	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		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)		48,207	0	48,207	2,080.00	23.18	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor: Direct Patient Care		665,533	0	665,533	9,875.00	67.40	11.00
12.00	Contract labor: Top level management and other management and administrative services		1,063,834	0	1,063,834	5,260.00	202.25	12.00
13.00	Contract labor: Physician-Part A - Administrative		2,523,616	0	2,523,616	30,309.00	83.26	13.00
14.00	Home office salaries & wage-related costs		5,200,279	0	5,200,279	83,123.00	62.56	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
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		13,899,173	0	13,899,173			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		3,336	0	3,336			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
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	1,438,985	0	1,438,985	8,320.00	172.95	26.00
27.00	Administrative & General	5.00	4,894,238	0	4,894,238	116,480.00	42.02	27.00
28.00	Administrative & General under contract (see inst.)		1,063,834	0	1,063,834	5,260.00	202.25	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,203,256	0	2,203,256	83,200.00	26.48	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,236,652	0	1,236,652	83,200.00	14.86	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,324,365	-490,015	834,350	52,000.00	16.05	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	490,015	490,015	31,200.00	15.71	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,302,516	0	2,302,516	54,080.00	42.58	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,976,792	0	1,976,792	41,600.00	47.52	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/25/2016 1:28 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
41.00	Medical Records & Medical Records Library	16.00	1,079,125	0	1,079,125	41,600.00	25.94	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: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/25/2016 1:28 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	54,658,972	0	54,658,972	1,685,900.00	32.42	1.00
2.00	Excluded area salaries (see instructions)	48,207	0	48,207	2,080.00	23.18	2.00
3.00	Subtotal salaries (line 1 minus line 2)	54,610,765	0	54,610,765	1,683,820.00	32.43	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,453,262	0	9,453,262	128,567.00	73.53	4.00
5.00	Subtotal wage-related costs (see inst.)	13,899,173	0	13,899,173	0.00	25.45	5.00
6.00	Total (sum of lines 3 thru 5)	77,963,200	0	77,963,200	1,812,387.00	43.02	6.00
7.00	Total overhead cost (see instructions)	17,519,763	0	17,519,763	516,940.00	33.89	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part IV Date/Time Prepared: 5/25/2016 1:28 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions		957,159	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		1,282,082	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
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
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		4,523,083	8.00
9.00	Prescription Drug Plan		1,286,770	9.00
10.00	Dental, Hearing and Vision Plan		139,291	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		62,700	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)		398,052	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		906,932	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
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		3,804,935	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		101,207	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		189,898	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		250,400	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		13,902,509	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part V Date/Time Prepared: 5/25/2016 1:28 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,505,687	13,241,990	1.00
2.00	Hospital	2,505,687	13,241,990	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 5/25/2016 1:28 pm
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				1.00		
<b>Uncompensated and indigent care cost computation</b>						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.254734		1.00	
<b>Medicaid (see instructions for each line)</b>						
2.00	Net revenue from Medicaid		36,204,561		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		178,880,019		6.00	
7.00	Medicaid cost (line 1 times line 6)		45,566,823		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)		9,362,262		8.00	
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>						
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	
<b>Other state or local government indigent care program (see instructions for each line)</b>						
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	
<b>Uncompensated care (see instructions for each line)</b>						
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)		9,362,262		19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility		6,338,647	1,392,353	7,731,000	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		1,614,669	354,680	1,969,349	21.00
22.00	Partial payment by patients approved for charity care		54,637	43,552	98,189	22.00
23.00	Cost of charity care (line 21 minus line 22)		1,560,032	311,128	1,871,160	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)		12,377,986			26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		1,317,926			27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		11,060,060			28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,817,373			29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,688,533			30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		14,050,795			31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A  
Date/Time Prepared:  
5/25/2016 1:28 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		0	4,340,825	4,340,825	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	3,200,475	3,200,475	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,438,985	9,997,137	-152	11,435,970	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,894,238	41,830,682	-4,390,101	42,334,819	5.00
7.00	00700	OPERATION OF PLANT	2,203,256	3,832,556	-32,854	6,002,958	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,236,652	903,166	-11,833	2,127,985	9.00
10.00	01000	DIETARY	1,324,365	1,302,860	-1,020,147	1,607,078	10.00
11.00	01100	CAFETERIA	0	0	972,073	972,073	11.00
13.00	01300	NURSING ADMINISTRATION	2,302,516	502,361	-10,458	2,794,419	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	1,976,792	6,573,739	-6,174,791	2,375,740	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,079,125	409,765	-2,849	1,486,041	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	15,486,554	5,728,106	-1,686,383	19,528,277	30.00
31.00	03100	INTENSIVE CARE UNIT	4,070,765	2,562,083	-797,551	5,835,297	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	831,111	162,981	-50,089	944,003	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,665,607	6,428,932	-4,967,752	5,126,787	50.00
51.00	05100	RECOVERY ROOM	530,294	132,590	-56,328	606,556	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	40,008	1,280,111	-154,735	1,165,384	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,296,180	5,025,670	-3,254,883	5,066,967	54.00
56.00	05600	RADIOISOTOPE	260,223	542,345	-457,522	345,046	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	603,861	1,599,272	-1,261,296	941,837	59.00
60.00	06000	LABORATORY	0	7,524,135	-565,122	6,959,013	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,111,174	512,451	-273,332	1,350,293	65.00
66.00	06600	PHYSICAL THERAPY	941,487	219,572	-31,847	1,129,212	66.00
67.00	06700	OCCUPATIONAL THERAPY	193,041	16,446	-1,591	207,896	67.00
68.00	06800	SPEECH PATHOLOGY	85,303	6,547	0	91,850	68.00
69.00	06900	ELECTROCARDIOLOGY	698,018	255,602	-83,333	870,287	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	51,484	18,572	-4,770	65,286	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	8,349,800	8,349,800	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	3,013,190	3,013,190	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	6,775,341	6,775,341	73.00
74.00	07400	RENAL DIALYSIS	459,733	430,903	-125,857	764,779	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	224,783	41,076	-16,019	249,840	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	437,101	336,273	-107,038	666,336	90.00
91.00	09100	EMERGENCY	4,104,275	3,859,102	-1,103,749	6,859,628	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	53,546,931	102,035,035	9,322	155,591,288	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	NONREIMPARAMED RT	0	0	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	48,207	254,782	-9,322	293,667	194.00
200.00		TOTAL (SUM OF LINES 118-199)	53,595,138	102,289,817	0	155,884,955	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A  
Date/Time Prepared:  
5/25/2016 1:28 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	173,929	4,514,754	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,027,022	4,227,497	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,940,165	13,376,135	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-16,627,476	25,707,343	5.00
7.00	00700	OPERATION OF PLANT	-64,055	5,938,903	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	2,127,985	9.00
10.00	01000	DIETARY	-2,062	1,605,016	10.00
11.00	01100	CAFETERIA	-654,619	317,454	11.00
13.00	01300	NURSING ADMINISTRATION	-960	2,793,459	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-89	2,375,651	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-18,955	1,467,086	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-1,935,337	17,592,940	30.00
31.00	03100	INTENSIVE CARE UNIT	-10,530	5,824,767	31.00
32.00	03200	CORONARY CARE UNIT	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	944,003	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-4,448	5,122,339	50.00
51.00	05100	RECOVERY ROOM	0	606,556	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,165,384	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-35,398	5,031,569	54.00
56.00	05600	RADIOISOTOPE	0	345,046	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	941,837	59.00
60.00	06000	LABORATORY	-174,825	6,784,188	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-570	1,349,723	65.00
66.00	06600	PHYSICAL THERAPY	-36,660	1,092,552	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	207,896	67.00
68.00	06800	SPEECH PATHOLOGY	0	91,850	68.00
69.00	06900	ELECTROCARDIOLOGY	-35	870,252	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	65,286	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,349,800	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,013,190	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,775,341	73.00
74.00	07400	RENAL DIALYSIS	0	764,779	74.00
76.00	03140	CARDIOLOGY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	249,840	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-34,231	632,105	90.00
91.00	09100	EMERGENCY	-554,476	6,305,152	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-17,013,610	138,577,678	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	NONREIMPARAMED RT	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	0	293,667	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-17,013,610	138,871,345	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>B - COST OF DRUGS 9929</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,775,341	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
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
<b>TOTALS</b>			0	6,775,341	
<b>C - MEDICAL SUPPLIES 9929</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	11,362,990	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
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
<b>TOTALS</b>			0	11,362,990	
<b>D - DERPRECIATION EXPENSE</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	4,340,825	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,200,475	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
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

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-6

Date/Time Prepared:  
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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
	TOTALS		0	7,541,300	
E - RECLASS CAFETERIA					
1.00	CAFETERIA	11.00	490,015	482,058	1.00
	TOTALS		490,015	482,058	
F - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO	72.00	0	3,013,190	1.00
	PATIENT				
	TOTALS		0	3,013,190	
500.00	Grand Total: Increases		490,015	29,174,879	500.00

RECLASSIFICATIONS

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-6  
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5/25/2016 1:28 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>B - COST OF DRUGS 9929</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,595	0		1.00
2.00	DIETARY	10.00	0	420	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	92	0		3.00
4.00	PHARMACY	15.00	0	6,072,039	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	184,979	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	75,370	0		6.00
7.00	NURSERY	43.00	0	1,482	0		7.00
8.00	OPERATING ROOM	50.00	0	142,056	0		8.00
9.00	RECOVERY ROOM	51.00	0	3,508	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	18,610	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	16,887	0		11.00
12.00	RADIOISOTOPE	56.00	0	1,409	0		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	5,682	0		13.00
15.00	PHYSICAL THERAPY	66.00	0	69	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	3,551	0		16.00
17.00	RENAL DIALYSIS	74.00	0	5,709	0		17.00
18.00	CLINIC	90.00	0	2,702	0		18.00
19.00	EMERGENCY	91.00	0	226,181	0		19.00
TOTALS			0	6,775,341			
<b>C - MEDICAL SUPPLIES 9929</b>							
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	87	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	76	0		2.00
3.00	OPERATION OF PLANT	7.00	0	336	0		3.00
4.00	HOUSEKEEPING	9.00	0	7,732	0		4.00
5.00	DIETARY	10.00	0	63	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	203	0		6.00
7.00	PHARMACY	15.00	0	42,563	0		7.00
8.00	NONREIMBURSABLE COST CENTERS	194.00	0	9,322	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	914,510	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	450,248	0		10.00
11.00	NURSERY	43.00	0	44,602	0		11.00
12.00	OPERATING ROOM	50.00	0	4,223,667	0		12.00
13.00	RECOVERY ROOM	51.00	0	19,070	0		13.00
14.00	ANESTHESIOLOGY	53.00	0	83,938	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,325,053	0		15.00
16.00	RADIOISOTOPE	56.00	0	454,791	0		16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	1,030,404	0		17.00
18.00	LABORATORY	60.00	0	553,577	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	223,866	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	23,088	0		20.00
21.00	OCCUPATIONAL THERAPY	67.00	0	1,591	0		21.00
23.00	ELECTROCARDIOLOGY	69.00	0	9,922	0		23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,670	0		24.00
25.00	RENAL DIALYSIS	74.00	0	114,155	0		25.00
26.00	CARDIAC REHABILITATION	76.97	0	1,436	0		26.00
27.00	CLINIC	90.00	0	100,500	0		27.00
28.00	EMERGENCY	91.00	0	725,520	0		28.00
TOTALS			0	11,362,990			
<b>D - DEPRECIATION EXPENSE</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	76	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	4,375,506	9		2.00
3.00	OPERATION OF PLANT	7.00	0	32,518	0		3.00
4.00	HOUSEKEEPING	9.00	0	4,101	0		4.00
5.00	DIETARY	10.00	0	47,591	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	10,163	0		6.00
7.00	PHARMACY	15.00	0	60,189	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,762	0		8.00
10.00	ADULTS & PEDIATRICS	30.00	0	586,894	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	271,933	0		11.00
12.00	NURSERY	43.00	0	4,005	0		12.00
13.00	OPERATING ROOM	50.00	0	602,029	0		13.00
14.00	RECOVERY ROOM	51.00	0	33,750	0		14.00
15.00	ANESTHESIOLOGY	53.00	0	52,187	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	912,943	0		16.00
17.00	RADIOISOTOPE	56.00	0	1,322	0		17.00
18.00	CARDIAC CATHETERIZATION	59.00	0	225,210	0		18.00
19.00	LABORATORY	60.00	0	11,545	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	49,466	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	8,690	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	69,860	0		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,100	0		23.00
24.00	RENAL DIALYSIS	74.00	0	5,993	0		24.00
25.00	CARDIAC REHABILITATION	76.97	0	14,583	0		25.00

RECLASSIFICATIONS

Provider CCN: 140048

Period:  
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To 12/31/2015

Worksheet A-6

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Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
26.00	CLINIC	90.00	0	3,836	0	26.00	
27.00	EMERGENCY	91.00	0	152,048	0	27.00	
	TOTALS		0	7,541,300			
E - RECLASS CAFETERIA							
1.00	DIETARY	10.00	490,015	482,058	0	1.00	
	TOTALS		490,015	482,058			
F - IMPLANTS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,013,190	0	1.00	
	TOTALS		0	3,013,190			
500.00	Grand Total: Decreases		490,015	29,174,879		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-7  
Part I  
Date/Time Prepared:  
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	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	3,847,978	0	0	0	1.00
2.00	Land Improvements	4,304,301	183,987	0	183,987	2.00
3.00	Buildings and Fixtures	99,980,938	17,519,390	0	17,519,390	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	42,106,775	5,631,420	0	5,631,420	5.00
6.00	Movable Equipment	160,117	0	0	0	6.00
7.00	HIT designated Assets	619,543	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	151,019,652	23,334,797	0	23,334,797	8.00
9.00	Reconciling Items	-17,241,610	4,208,926	0	4,208,926	9.00
10.00	Total (line 8 minus line 9)	168,261,262	19,125,871	0	19,125,871	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	3,847,978	0			1.00
2.00	Land Improvements	4,488,288	1,032,001			2.00
3.00	Buildings and Fixtures	111,587,594	24,750,226			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	42,583,522	19,210,144			5.00
6.00	Movable Equipment	131,759	74,980			6.00
7.00	HIT designated Assets	619,543	268,849			7.00
8.00	Subtotal (sum of lines 1-7)	163,258,684	45,336,200			8.00
9.00	Reconciling Items	-13,032,684	0			9.00
10.00	Total (line 8 minus line 9)	176,291,368	45,336,200			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-7  
Part II  
Date/Time Prepared:  
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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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	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	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet A-7 Part III Date/Time Prepared: 5/25/2016 1:28 pm
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL	
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance
		1.00	2.00	3.00	4.00	5.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	4	0	4	0.800000	0
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1	0	1	0.200000	0
3.00	Total (sum of lines 1-2)	5	0	5	1.000000	0
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL	
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	4,514,754	0
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	4,227,497	0
3.00	Total (sum of lines 1-2)	0	0	0	8,742,251	0
Cost Center Description		SUMMARY OF CAPITAL				
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)
		11.00	12.00	13.00	14.00	15.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	4,514,754
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,227,497
3.00	Total (sum of lines 1-2)	0	0	0	0	8,742,251

ADJUSTMENTS TO EXPENSES

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW 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	-2,523,295			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	-3,088,520			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-654,619	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts		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		ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW 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		OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			OADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

33.00	NONALLOWABLE INTEREST EXPENSE	A	-1,590,215	Expense Classification on Worksheet A		5.00	0	33.00
				To/From Which the Amount is to be Adjusted				
				Cost Center	Line #			
37.00				3.00	4.00	5.00		
37.00			0	ADMINISTRATIVE & GENERAL		0.00	0	37.00
38.00	MEDICAID ASSESSMENT FROM F/S	A	-7,514,360	ADMINISTRATIVE & GENERAL		5.00	0	38.00
40.00	PBP	A	-163,072	ADMINISTRATIVE & GENERAL		5.00	0	40.00
41.00	CANON OFFSET	A	-70	NEW CAP REL COSTS-BLDG & FIXT		1.00	9	41.00
42.00	ADD MEDICARE DEPRECIATION	A	-75,507	NEW CAP REL COSTS-BLDG & FIXT		1.00	9	42.00
43.00	ADD MEDICARE DEPRECIATION	A	3,729	NEW CAP REL COSTS-MVBLE EQUIP		2.00	9	43.00
44.00	AMBULANCE	A	-1,819	EMERGENCY		91.00	0	44.00
45.00	LOBBYING COSTS	A	-32,951	ADMINISTRATIVE & GENERAL		5.00	0	45.00
45.05	PHO EXPENSE	A	-876,104	ADMINISTRATIVE & GENERAL		5.00	0	45.05
45.06			0			0.00	0	45.06
45.07	MISC INCOME	B	-174,825	LABORATORY		60.00	0	45.07
45.08	MISC INCOME	B	-61,303	ADMINISTRATIVE & GENERAL		5.00	0	45.08
45.09	MISC INCOME	B	-628	ADULTS & PEDIATRICS		30.00	0	45.09
45.10	MISC INCOME	B	-62,071	OPERATION OF PLANT		7.00	0	45.10
45.11			0			0.00	0	45.11
45.12	MISC INCOME	B	-17,401	MEDICAL RECORDS & LIBRARY		16.00	0	45.12
45.13	MISC INCOME	B	-32,663	RADIOLOGY-DIAGNOSTIC		54.00	0	45.13
45.14	MISC INCOME	B	-270	RESPIRATORY THERAPY		65.00	0	45.14
45.15	MISC INCOME	B	-6,886	CLINIC		90.00	0	45.15
45.16			0			0.00	0	45.16
45.17	MISC INCOME	B	-9,360	PHYSICAL THERAPY		66.00	0	45.17
45.18	NON ALLOWABLE	A	-48,343	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	45.18
45.19	NON ALLOWABLE	A	-39,644	ADMINISTRATIVE & GENERAL		5.00	0	45.19
45.20	NON ALLOWABLE	A	-1,984	OPERATION OF PLANT		7.00	0	45.20
45.21	NON ALLOWABLE	A	-4,448	OPERATING ROOM		50.00	0	45.21
45.22			0			0.00	0	45.22
45.23	NON ALLOWABLE	A	-89	PHARMACY		15.00	0	45.23
45.24	NON ALLOWABLE	A	-1,554	MEDICAL RECORDS & LIBRARY		16.00	0	45.24
45.25			0			0.00	0	45.25
45.26			0			0.00	0	45.26
45.27	NON ALLOWABLE	A	-8,740	EMERGENCY		91.00	0	45.27
45.28	NON ALLOWABLE	A	-960	NURSING ADMINISTRATIVE		13.00	0	45.28
45.29	NON ALLOWABLE	A	-2,062	DIETARY		10.00	0	45.29
45.30	NON ALLOWABLE	A	-300	RESPIRATORY THERAPY		65.00	0	45.30
45.31			0			0.00	0	45.31
45.45	NON ALLOWABLE	A	-10,530	INTENSIVE CARE UNIT		31.00	0	45.45
45.46	NON ALLOWABLE	A	-9,976	ADULTS & PEDIATRICS		30.00	0	45.46
45.47	NON ALLOWABLE	A	-35	ELECTROCARDIOLOGY		69.00	0	45.47
45.48	NON ALLOWABLE	A	-2,735	RADIOLOGY-DIAGNOSTIC		54.00	0	45.48
45.49			0			0.00	0	45.49
45.50			0			0.00	0	45.50
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-17,013,610					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: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-8-1

Date/Time Prepared:  
5/25/2016 1:28 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	PERSONNEL	1,988,508	0
2.00	5.00	ADMINISTRATIVE & GENERAL	DATA PROCESSING	1,852,796	0
3.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	4,294,640	12,497,263
4.00	1.00	NEW CAP REL COSTS-BLDG & FIX	DEPRECIATION	249,506	0
4.01	2.00	NEW CAP REL COSTS-MVBLE EQUI	DEPRECIATION	1,023,293	0
4.02	0.00			0	0
4.03	0.00			0	0
5.00	0	0	0	9,408,743	12,497,263

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

Symbol (1)	Name	Percentage of Ownership	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	TRINITY HOSPITAL	100.00	ADVOCATE HEALTHCARE	100.00	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: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-8-1

Date/Time Prepared:  
5/25/2016 1:28 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	1,988,508	0		1.00
2.00	1,852,796	0		2.00
3.00	-8,202,623	0		3.00
4.00	249,506	9		4.00
4.01	1,023,293	9		4.01
4.02	0	0		4.02
4.03	0	0		4.03
5.00	-3,088,520			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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	HEALTH CARE		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: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-8-2

Date/Time Prepared:  
5/25/2016 1:28 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,924,733	1,924,733	0	0	1	1.00
2.00	0.00		0	0	0	0	1	2.00
3.00	0.00		0	0	0	0	1	3.00
4.00	91.00	EMERGENCY	543,917	543,917	0	0	1	4.00
5.00	66.00	PHYSICAL THERAPY	27,300	27,300	0	0	1	5.00
6.00	0.00		0	0	0	0	1	6.00
7.00	90.00	CLINIC	27,345	27,345	0	0	1	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,523,295	2,523,295	0	0	7	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,924,733	1.00
2.00	0.00		0	0	0	0	2.00
3.00	0.00		0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	543,917	4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	27,300	5.00
6.00	0.00		0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	27,345	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	2,523,295	200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part I Date/Time Prepared: 5/25/2016 1:28 pm
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	4,514,754	4,514,754			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	4,227,497		4,227,497		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	13,376,135	57,093	53,461	13,486,689	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	25,707,343	524,541	491,167	1,312,794	5.00
7.00 00700	OPERATION OF PLANT	5,938,903	672,554	629,762	537,684	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	41,350	38,719	0	8.00
9.00 00900	HOUSEKEEPING	2,127,985	60,286	56,450	324,782	9.00
10.00 01000	DIETARY	1,605,016	130,199	121,915	206,619	10.00
11.00 01100	CAFETERIA	317,454	76,472	71,607	121,347	11.00
13.00 01300	NURSING ADMINISTRATION	2,793,459	50,091	46,904	601,837	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	2,375,651	64,270	60,180	521,566	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,467,086	44,100	41,294	305,659	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	17,592,940	1,063,037	995,401	4,034,905	30.00
31.00 03100	INTENSIVE CARE UNIT	5,824,767	283,855	265,794	989,785	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	944,003	31,945	29,913	214,237	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	5,122,339	469,677	439,793	933,965	50.00
51.00 05100	RECOVERY ROOM	606,556	0	0	150,494	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	1,165,384	0	0	9,230	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,031,569	249,981	234,076	807,155	54.00
56.00 05600	RADIOISOTOPE	345,046	18,826	17,628	62,958	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	941,837	15,143	14,179	127,285	59.00
60.00 06000	LABORATORY	6,784,188	100,783	94,370	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	1,349,723	38,205	35,774	280,144	65.00
66.00 06600	PHYSICAL THERAPY	1,092,552	87,774	82,189	238,188	66.00
67.00 06700	OCCUPATIONAL THERAPY	207,896	6,987	6,542	51,094	67.00
68.00 06800	SPEECH PATHOLOGY	91,850	2,166	2,028	24,440	68.00
69.00 06900	ELECTROCARDIOLOGY	870,252	56,999	53,372	175,933	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	65,286	1,992	1,865	10,986	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,349,800	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	3,013,190	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	6,775,341	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	764,779	11,602	10,864	120,199	74.00
76.00 03140	CARDIOLOGY	0	0	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	249,840	40,196	37,639	54,006	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	632,105	28,879	27,041	148,125	90.00
91.00 09100	EMERGENCY	6,305,152	248,527	232,714	1,093,254	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	138,577,678	4,477,530	4,192,641	13,458,671	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	NONREIM PARAMED RT	0	0	0	0	192.01
194.00 07951	NONREIMBURSABLE COST CENTERS	293,667	37,224	34,856	28,018	194.00
200.00	Cross Foot Adjustments	0	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part I  
Date/Time Prepared:  
5/25/2016 1:28 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
201.00   Negative Cost Centers		0	0	0		201.00
202.00   TOTAL (sum lines 118-201)	138,871,345	4,514,754	4,227,497	13,486,689	138,871,345	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part I Date/Time Prepared: 5/25/2016 1:28 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	28,035,845				5.00	
7.00	00700	OPERATION OF PLANT	1,967,674	9,746,577			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	20,253	123,605	223,927		8.00	
9.00	00900	HOUSEKEEPING	649,956	180,210	0	3,399,669	9.00	
10.00	01000	DIETARY	522,025	389,194	0	140,121	3,115,089	10.00
11.00	01100	CAFETERIA	148,451	228,593	0	82,300	1,866,379	11.00
13.00	01300	NURSING ADMINISTRATION	883,375	149,734	0	53,908	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	764,331	192,116	0	69,167	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	470,016	131,826	0	47,461	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	5,991,449	3,177,670	105,817	1,144,057	1,001,282	30.00
31.00	03100	INTENSIVE CARE UNIT	1,862,775	848,506	10,633	305,487	247,428	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	308,624	95,491	18,315	34,380	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,761,993	1,403,971	17,634	505,470	0	50.00
51.00	05100	RECOVERY ROOM	191,496	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	297,119	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,599,347	747,251	29,287	269,032	0	54.00
56.00	05600	RADIOISOTOPE	112,426	56,274	0	20,260	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	277,851	45,265	2,199	16,297	0	59.00
60.00	06000	LABORATORY	1,765,424	301,263	1,850	108,463	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	430,988	114,202	0	41,116	0	65.00
66.00	06600	PHYSICAL THERAPY	379,603	262,376	1,813	94,463	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	68,934	20,884	0	7,519	0	67.00
68.00	06800	SPEECH PATHOLOGY	30,476	6,473	0	2,331	0	68.00
69.00	06900	ELECTROCARDIOLOGY	292,551	170,382	3,018	61,342	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,269	5,953	0	2,143	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,112,082	0	48	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	762,186	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,713,823	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	229,538	34,681	0	12,486	0	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	96,546	120,155	386	43,259	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	211,504	86,325	0	31,079	0	90.00
91.00	09100	EMERGENCY	1,993,157	742,904	32,927	267,467	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,936,242	9,635,304	223,927	3,359,608	3,115,089	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NONREIM PARAMED RT	0	0	0	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	99,603	111,273	0	40,061	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	28,035,845	9,746,577	223,927	3,399,669	3,115,089	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140048		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part I Date/Time Prepared: 5/25/2016 1:28 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	2,912,603					11.00
13.00	01300	159,596	4,738,904				13.00
14.00	01400	0	0	0			14.00
15.00	01500	138,310	0	0	4,185,591		15.00
16.00	01600	81,055	0	0	0	2,588,497	16.00
17.00	01700	0	0	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,069,975	2,569,660	0	114,527	1,110,248	30.00
31.00	03100	262,473	639,904	0	46,664	5,107	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	56,812	90,314	0	918	98,172	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	247,670	491,733	0	87,952	450,852	50.00
51.00	05100	39,908	71,783	0	2,172	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	2,448	6,043	0	11,522	0	53.00
54.00	05400	214,042	41,620	0	10,455	303,311	54.00
56.00	05600	16,695	0	0	872	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	33,753	67,830	0	3,518	0	59.00
60.00	06000	0	0	0	0	60,435	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	74,289	0	0	0	0	65.00
66.00	06600	63,163	6,161	0	43	2,837	66.00
67.00	06700	13,549	0	0	0	0	67.00
68.00	06800	6,481	0	0	0	0	68.00
69.00	06900	46,654	73,596	0	2,199	24,685	69.00
70.00	07000	2,913	7,568	0	0	1,986	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	3,759,424	0	73.00
74.00	07400	31,875	61,447	0	3,535	0	74.00
76.00	03140	0	0	0	0	0	76.00
76.97	07697	14,321	4,919	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	39,280	15,868	0	1,673	4,256	90.00
91.00	09100	289,911	590,458	0	140,037	498,235	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		2,905,173	4,738,904	0	4,185,511	2,560,124	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07951	7,430	0	0	80	28,373	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,912,603	4,738,904	0	4,185,591	2,588,497	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part I Date/Time Prepared: 5/25/2016 1:28 pm
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Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
		17.00	21.00			22.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	0			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	0	0	39,970,968	0 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	11,593,178	0 31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0 32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0 33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0 34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0 41.00
42.00	04200	SUBPROVIDER	0	0	0	0 42.00
43.00	04300	NURSERY	0	0	1,923,124	0 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	0	11,933,049	0 50.00
51.00	05100	RECOVERY ROOM	0	0	1,062,409	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,491,746	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	9,537,126	0 54.00
56.00	05600	RADIOISOTOPE	0	0	650,985	0 56.00
57.00	05700	CT SCAN	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	1,545,157	0 59.00
60.00	06000	LABORATORY	0	0	9,216,776	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0	0	2,364,441	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,311,162	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	383,405	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	166,245	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,830,983	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	120,961	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	10,461,930	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	3,775,376	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	12,248,588	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	1,281,006	0 74.00
76.00	03140	CARDIOLOGY	0	0	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	661,267	0 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0 89.00
90.00	09000	CLINIC	0	0	1,226,135	0 90.00
91.00	09100	EMERGENCY	0	0	12,434,743	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910	CORF	0	0	0	0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0 109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0 110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0 111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	138,190,760	0 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0 192.00
192.01	19201	NONREIM PARAMED RT	0	0	0	0 192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	0	0	680,585	0 194.00
200.00		Cross Foot Adjustments		0	0	0 200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part I  
Date/Time Prepared:  
5/25/2016 1:28 pm

Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
	17.00	21.00	22.00	24.00	25.00	
201.00   Negative Cost Centers	0	0	0	0	0	201.00
202.00   TOTAL (sum lines 118-201)	0	0	0	138,871,345	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part I  
Date/Time Prepared:  
5/25/2016 1:28 pm

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS	39,970,968	30.00
31.00	03100 INTENSIVE CARE UNIT	11,593,178	31.00
32.00	03200 CORONARY CARE UNIT	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	34.00
41.00	04100 SUBPROVIDER - IRF	0	41.00
42.00	04200 SUBPROVIDER	0	42.00
43.00	04300 NURSERY	1,923,124	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	11,933,049	50.00
51.00	05100 RECOVERY ROOM	1,062,409	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300 ANESTHESIOLOGY	1,491,746	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	9,537,126	54.00
56.00	05600 RADIOISOTOPE	650,985	56.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,545,157	59.00
60.00	06000 LABORATORY	9,216,776	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
65.00	06500 RESPIRATORY THERAPY	2,364,441	65.00
66.00	06600 PHYSICAL THERAPY	2,311,162	66.00
67.00	06700 OCCUPATIONAL THERAPY	383,405	67.00
68.00	06800 SPEECH PATHOLOGY	166,245	68.00
69.00	06900 ELECTROCARDIOLOGY	1,830,983	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	120,961	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10,461,930	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3,775,376	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12,248,588	73.00
74.00	07400 RENAL DIALYSIS	1,281,006	74.00
76.00	03140 RADIOLOGY	0	76.00
76.97	07697 CARDIAC REHABILITATION	661,267	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800 RURAL HEALTH CLINIC	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000 CLINIC	1,226,135	90.00
91.00	09100 EMERGENCY	12,434,743	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10	09910 CORF	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>			
109.00	10900 PANCREAS ACQUISITION	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	110.00
111.00	11100 ISLET ACQUISITION	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	138,190,760	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201 NONREIM PARAMED RT	0	192.01
194.00	07951 NONREIMBURSABLE COST CENTERS	680,585	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	138,871,345	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part II  
Date/Time Prepared:  
5/25/2016 1:28 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2. 00			
<b>GENERAL SERVICE COST CENTERS</b>						
1. 00 00100	NEW CAP REL COSTS-BLDG & FIXT					1. 00
2. 00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2. 00
4. 00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	57,093	53,461	110,554	4. 00
5. 00 00500	ADMINISTRATIVE & GENERAL	0	524,541	491,167	1,015,708	5. 00
7. 00 00700	OPERATION OF PLANT	0	672,554	629,762	1,302,316	7. 00
8. 00 00800	LAUNDRY & LINEN SERVICE	0	41,350	38,719	80,069	8. 00
9. 00 00900	HOUSEKEEPING	0	60,286	56,450	116,736	9. 00
10. 00 01000	DIETARY	0	130,199	121,915	252,114	10. 00
11. 00 01100	CAFETERIA	0	76,472	71,607	148,079	11. 00
13. 00 01300	NURSING ADMINISTRATION	0	50,091	46,904	96,995	13. 00
14. 00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14. 00
15. 00 01500	PHARMACY	0	64,270	60,180	124,450	15. 00
16. 00 01600	MEDICAL RECORDS & LIBRARY	0	44,100	41,294	85,394	16. 00
17. 00 01700	SOCIAL SERVICE	0	0	0	0	17. 00
21. 00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21. 00
22. 00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22. 00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30. 00 03000	ADULTS & PEDIATRICS	0	1,063,037	995,401	2,058,438	30. 00
31. 00 03100	INTENSIVE CARE UNIT	0	283,855	265,794	549,649	31. 00
32. 00 03200	CORONARY CARE UNIT	0	0	0	0	32. 00
33. 00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33. 00
34. 00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34. 00
41. 00 04100	SUBPROVIDER - IRF	0	0	0	0	41. 00
42. 00 04200	SUBPROVIDER	0	0	0	0	42. 00
43. 00 04300	NURSERY	0	31,945	29,913	61,858	43. 00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50. 00 05000	OPERATING ROOM	0	469,677	439,793	909,470	50. 00
51. 00 05100	RECOVERY ROOM	0	0	0	0	51. 00
52. 00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52. 00
53. 00 05300	ANESTHESIOLOGY	0	0	0	0	53. 00
54. 00 05400	RADIOLOGY-DIAGNOSTIC	0	249,981	234,076	484,057	54. 00
56. 00 05600	RADIOISOTOPE	0	18,826	17,628	36,454	56. 00
57. 00 05700	CT SCAN	0	0	0	0	57. 00
58. 00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58. 00
59. 00 05900	CARDIAC CATHETERIZATION	0	15,143	14,179	29,322	59. 00
60. 00 06000	LABORATORY	0	100,783	94,370	195,153	60. 00
60. 01 06001	BLOOD LABORATORY	0	0	0	0	60. 01
65. 00 06500	RESPIRATORY THERAPY	0	38,205	35,774	73,979	65. 00
66. 00 06600	PHYSICAL THERAPY	0	87,774	82,189	169,963	66. 00
67. 00 06700	OCCUPATIONAL THERAPY	0	6,987	6,542	13,529	67. 00
68. 00 06800	SPEECH PATHOLOGY	0	2,166	2,028	4,194	68. 00
69. 00 06900	ELECTROCARDIOLOGY	0	56,999	53,372	110,371	69. 00
70. 00 07000	ELECTROENCEPHALOGRAPHY	0	1,992	1,865	3,857	70. 00
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71. 00
72. 00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72. 00
73. 00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73. 00
74. 00 07400	RENAL DIALYSIS	0	11,602	10,864	22,466	74. 00
76. 00 03140	CARDIOLOGY	0	0	0	0	76. 00
76. 97 07697	CARDIAC REHABILITATION	0	40,196	37,639	77,835	76. 97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88. 00 08800	RURAL HEALTH CLINIC	0	0	0	0	88. 00
89. 00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89. 00
90. 00 09000	CLINIC	0	28,879	27,041	55,920	90. 00
91. 00 09100	EMERGENCY	0	248,527	232,714	481,241	91. 00
92. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92. 00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99. 10 09910	CORF	0	0	0	0	99. 10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109. 00 10900	PANCREAS ACQUISITION	0	0	0	0	109. 00
110. 00 11000	INTESTINAL ACQUISITION	0	0	0	0	110. 00
111. 00 11100	ISLET ACQUISITION	0	0	0	0	111. 00
118. 00 0	SUBTOTALS (SUM OF LINES 1-117)	0	4,477,530	4,192,641	8,670,171	118. 00
<b>NONREIMBURSABLE COST CENTERS</b>						
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192. 00
192. 01 19201	NONREIM PARAMED RT	0	0	0	0	192. 01
194. 00 07951	NONREIMBURSABLE COST CENTERS	0	37,224	34,856	72,080	194. 00
200. 00 0	Cross Foot Adjustments	0	0	0	0	200. 00
201. 00 0	Negative Cost Centers	0	0	0	0	201. 00

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
202.00	TOTAL (sum lines 118-201)	0	4,514,754	4,227,497	8,742,251	110,554	202.00

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part II  
Date/Time Prepared:  
5/25/2016 1:28 pm

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/25/2016 1:28 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	1,026,468				5.00	
7.00	00700	OPERATION OF PLANT	72,040	1,378,763			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	742	17,485	98,296		8.00	
9.00	00900	HOUSEKEEPING	23,796	25,493	0	168,687	9.00	
10.00	01000	DIETARY	19,112	55,056	0	6,953	334,929	10.00
11.00	01100	CAFETERIA	5,435	32,337	0	4,084	200,670	11.00
13.00	01300	NURSING ADMINISTRATION	32,342	21,182	0	2,675	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	27,984	27,177	0	3,432	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,208	18,648	0	2,355	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	219,380	449,517	46,451	56,765	107,656	30.00
31.00	03100	INTENSIVE CARE UNIT	68,200	120,031	4,667	15,158	26,603	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	11,299	13,508	8,039	1,706	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	64,510	198,608	7,741	25,081	0	50.00
51.00	05100	RECOVERY ROOM	7,011	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	10,878	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,555	105,707	12,856	13,349	0	54.00
56.00	05600	RADIOISOTOPE	4,116	7,961	0	1,005	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,173	6,403	965	809	0	59.00
60.00	06000	LABORATORY	64,636	42,617	812	5,382	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	15,779	16,155	0	2,040	0	65.00
66.00	06600	PHYSICAL THERAPY	13,898	37,116	796	4,687	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,524	2,954	0	373	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,116	916	0	116	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,711	24,102	1,325	3,044	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	742	842	0	106	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,327	0	21	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	27,905	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,746	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	8,404	4,906	0	620	0	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,535	16,997	169	2,146	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	7,744	12,212	0	1,542	0	90.00
91.00	09100	EMERGENCY	72,973	105,092	14,454	13,271	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,022,821	1,363,022	98,296	166,699	334,929	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NONREIM PARAMED RT	0	0	0	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	3,647	15,741	0	1,988	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,026,468	1,378,763	98,296	168,687	334,929	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140048		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 5/25/2016 1:28 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	391,600					11.00
13.00	01300	21,458	179,585				13.00
14.00	01400	0	0	0			14.00
15.00	01500	18,596	0	0	205,914		15.00
16.00	01600	10,898	0	0	0	137,008	16.00
17.00	01700	0	0	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	143,854	97,380	0	5,634	58,766	30.00
31.00	03100	35,290	24,250	0	2,296	270	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	7,638	3,423	0	45	5,196	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	33,300	18,635	0	4,327	23,863	50.00
51.00	05100	5,366	2,720	0	107	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	329	229	0	567	0	53.00
54.00	05400	28,779	1,577	0	514	16,054	54.00
56.00	05600	2,245	0	0	43	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	4,538	2,570	0	173	0	59.00
60.00	06000	0	0	0	0	3,199	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	9,988	0	0	0	0	65.00
66.00	06600	8,492	233	0	2	150	66.00
67.00	06700	1,822	0	0	0	0	67.00
68.00	06800	871	0	0	871	0	68.00
69.00	06900	6,273	2,789	0	108	1,307	69.00
70.00	07000	392	287	0	0	105	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	184,949	0	73.00
74.00	07400	4,286	2,329	0	174	0	74.00
76.00	03140	0	0	0	0	0	76.00
76.97	07697	1,926	186	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	5,281	601	0	82	225	90.00
91.00	09100	38,979	22,376	0	6,889	26,371	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		390,601	179,585	0	205,910	135,506	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07951	999	0	0	4	1,502	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		391,600	179,585	0	205,914	137,008	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/25/2016 1:28 pm	
Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
		SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
	17.00	21.00	22.00	24.00	25.00
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	0		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	3,276,924	0 30.00
31.00	03100	INTENSIVE CARE UNIT	0	854,527	0 31.00
32.00	03200	CORONARY CARE UNIT	0	0	0 32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0 33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0 34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0 41.00
42.00	04200	SUBPROVIDER	0	0	0 42.00
43.00	04300	NURSERY	0	114,468	0 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	1,293,190	0 50.00
51.00	05100	RECOVERY ROOM	0	16,437	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	12,079	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	728,064	0 54.00
56.00	05600	RADIOISOTOPE	0	52,340	0 56.00
57.00	05700	CT SCAN	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	55,996	0 59.00
60.00	06000	LABORATORY	0	311,799	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0	120,237	0 65.00
66.00	06600	PHYSICAL THERAPY	0	237,289	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	21,621	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	7,413	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	161,472	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,421	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	77,348	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	27,905	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	247,695	0 73.00
74.00	07400	RENAL DIALYSIS	0	44,170	0 74.00
76.00	03140	CARDIOLOGY	0	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	103,237	0 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0 89.00
90.00	09000	CLINIC	0	84,821	0 90.00
91.00	09100	EMERGENCY	0	790,607	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	CORF	0	0	0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900	PANCREAS ACQUISITION	0	0	0 109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0 110.00
111.00	11100	ISLET ACQUISITION	0	0	0 111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0 118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0 192.00
192.01	19201	NONREIM PARAMED RT	0	0	0 192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	0	96,191	0 194.00
200.00		Cross Foot Adjustments	0	0	0 200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part II  
Date/Time Prepared:  
5/25/2016 1:28 pm

Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
	17.00	21.00	22.00	24.00	25.00	
201.00   Negative Cost Centers	0	0	0	0	0	201.00
202.00   TOTAL (sum lines 118-201)	0	0	0	8,742,251	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/25/2016 1:28 pm
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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS	3,276,924	30.00
31.00	03100 INTENSIVE CARE UNIT	854,527	31.00
32.00	03200 CORONARY CARE UNIT	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	34.00
41.00	04100 SUBPROVIDER - IRF	0	41.00
42.00	04200 SUBPROVIDER	0	42.00
43.00	04300 NURSERY	114,468	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	1,293,190	50.00
51.00	05100 RECOVERY ROOM	16,437	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300 ANESTHESIOLOGY	12,079	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	728,064	54.00
56.00	05600 RADIOISOTOPE	52,340	56.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	55,996	59.00
60.00	06000 LABORATORY	311,799	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
65.00	06500 RESPIRATORY THERAPY	120,237	65.00
66.00	06600 PHYSICAL THERAPY	237,289	66.00
67.00	06700 OCCUPATIONAL THERAPY	21,621	67.00
68.00	06800 SPEECH PATHOLOGY	7,413	68.00
69.00	06900 ELECTROCARDIOLOGY	161,472	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	6,421	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	77,348	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	27,905	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	247,695	73.00
74.00	07400 RENAL DIALYSIS	44,170	74.00
76.00	03140 CARDIOLOGY	0	76.00
76.97	07697 CARDIAC REHABILITATION	103,237	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800 RURAL HEALTH CLINIC	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000 CLINIC	84,821	90.00
91.00	09100 EMERGENCY	790,607	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10	09910 CORF	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>			
109.00	10900 PANCREAS ACQUISITION	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	110.00
111.00	11100 ISLET ACQUISITION	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	8,646,060	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201 NONREIM PARAMED RT	0	192.01
194.00	07951 NONREIMBURSABLE COST CENTERS	96,191	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	8,742,251	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B-1  
Date/Time Prepared:  
5/25/2016 1:28 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQ. FEET OLD)	NEW MVBLE EQUIP (SQ. FEET OLD)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	285,625				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		285,625			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,612	3,612	52,865,011		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	33,185	33,185	5,145,870	-28,035,845	110,835,500
7.00 00700	OPERATION OF PLANT	42,549	42,549	2,107,606	0	7,778,903
8.00 00800	LAUNDRY & LINEN SERVICE	2,616	2,616	0	0	80,069
9.00 00900	HOUSEKEEPING	3,814	3,814	1,273,074	0	2,569,503
10.00 01000	DIETARY	8,237	8,237	809,902	0	2,063,749
11.00 01100	CAFETERIA	4,838	4,838	475,656	0	586,880
13.00 01300	NURSING ADMINISTRATION	3,169	3,169	2,359,072	0	3,492,291
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	4,066	4,066	2,044,426	0	3,021,667
16.00 01600	MEDICAL RECORDS & LIBRARY	2,790	2,790	1,198,116	0	1,858,139
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	67,253	67,253	15,816,053	0	23,686,283
31.00 03100	INTENSIVE CARE UNIT	17,958	17,958	3,879,746	0	7,364,201
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	2,021	2,021	839,763	0	1,220,098
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	29,714	29,714	3,660,942	0	6,965,774
51.00 05100	RECOVERY ROOM	0	0	589,904	0	757,050
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	0	0	36,181	0	1,174,614
54.00 05400	RADIOLOGY-DIAGNOSTIC	15,815	15,815	3,163,873	0	6,322,781
56.00 05600	RADIOISOTOPE	1,191	1,191	246,782	0	444,458
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	958	958	498,928	0	1,098,444
60.00 06000	LABORATORY	6,376	6,376	0	0	6,979,341
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	2,417	2,417	1,098,103	0	1,703,846
66.00 06600	PHYSICAL THERAPY	5,553	5,553	933,647	0	1,500,703
67.00 06700	OCCUPATIONAL THERAPY	442	442	200,276	0	272,519
68.00 06800	SPEECH PATHOLOGY	137	137	95,801	0	120,484
69.00 06900	ELECTROCARDIOLOGY	3,606	3,606	689,618	0	1,156,556
70.00 07000	ELECTROENCEPHALOGRAPHY	126	126	43,062	0	80,129
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	8,349,800
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,013,190
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	6,775,341
74.00 07400	RENAL DIALYSIS	734	734	471,155	0	907,444
76.00 03140	CARDIOLOGY	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	2,543	2,543	211,690	0	381,681
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00 09000	CLINIC	1,827	1,827	580,618	0	836,150
91.00 09100	EMERGENCY	15,723	15,723	4,285,322	0	7,879,647
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00 11100	ISLET ACQUISITION	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	283,270	283,270	52,755,186	-28,035,845	110,441,735
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01 19201	NONREIM PARAMED RT	0	0	0	0	0
194.00 07951	NONREIMBURSABLE COST CENTERS	2,355	2,355	109,825	0	393,765
200.00	Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B-1

Date/Time Prepared:  
5/25/2016 1:28 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQ. FEET OLD)	NEW MVBLE EQUIP (SQ. FEET OLD)				
		1.00	2.00				
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4,514,754	4,227,497	13,486,689		28,035,845	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	15.806579	14.800865	0.255116		0.252950	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			110,554		1,026,468	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.002091		0.009261	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B-1  
Date/Time Prepared:  
5/25/2016 1:28 pm

Cost Center Description		OPERATION OF PLANT (SQ. FEET OLD)	LAUNDRY & LINEN SERVICE (LAUNDRY LBS)	HOUSEKEEPING (SQ. FEET OLD)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)		
		7.00	8.00	9.00	10.00	11.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	206,279				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	2,616	861,687			8.00	
9.00	00900	HOUSEKEEPING	3,814	0	199,849		9.00	
10.00	01000	DIETARY	8,237	0	8,237	382,544	10.00	
11.00	01100	CAFETERIA	4,838	0	4,838	229,198	43,052,903	11.00
13.00	01300	NURSING ADMINISTRATION	3,169	0	3,169	0	2,359,072	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	4,066	0	4,066	0	2,044,426	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,790	0	2,790	0	1,198,116	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	67,253	407,191	67,253	122,961	15,816,053	30.00
31.00	03100	INTENSIVE CARE UNIT	17,958	40,916	17,958	30,385	3,879,746	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	2,021	70,476	2,021	0	839,763	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	29,714	67,858	29,714	0	3,660,942	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	589,904	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	36,181	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,815	112,699	15,815	0	3,163,873	54.00
56.00	05600	RADIOISOTOPE	1,191	0	1,191	0	246,782	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	958	8,463	958	0	498,928	59.00
60.00	06000	LABORATORY	6,376	7,120	6,376	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,417	0	2,417	0	1,098,103	65.00
66.00	06600	PHYSICAL THERAPY	5,553	6,977	5,553	0	933,647	66.00
67.00	06700	OCCUPATIONAL THERAPY	442	0	442	0	200,276	67.00
68.00	06800	SPEECH PATHOLOGY	137	0	137	0	95,801	68.00
69.00	06900	ELECTROCARDIOLOGY	3,606	11,614	3,606	0	689,618	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	126	0	126	0	43,062	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	184	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	734	0	734	0	471,155	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,543	1,484	2,543	0	211,690	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,827	0	1,827	0	580,618	90.00
91.00	09100	EMERGENCY	15,723	126,705	15,723	0	4,285,322	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	203,924	861,687	197,494	382,544	42,943,078	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NONREIM PARAMED RT	0	0	0	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	2,355	0	2,355	0	109,825	194.00
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)	9,746,577	223,927	3,399,669	3,115,089	2,912,603	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B-1

Date/Time Prepared:  
5/25/2016 1:28 pm

Cost Center Description		OPERATION OF PLANT (SQ. FEET OLD)	LAUNDRY & LINEN SERVICE (LAUNDRY LBS)	HOUSEKEEPING (SQ. FEET OLD)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	
		7.00	8.00	9.00	10.00	11.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	47.249487	0.259870	17.011188	8.143087	0.067652	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,378,763	98,296	168,687	334,929	391,600	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	6.683972	0.114074	0.844072	0.875531	0.009096	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B-1

Date/Time Prepared:  
5/25/2016 1:28 pm

Cost Center Description		NURSING ADMINISTRATION (NSG FTE)	CENTRAL SERVICES & SUPPLY (MED SUPPL COSTS)	PHARMACY (PHARM COSTS)	MEDICAL RECORDS & LIBRARY (MED REC TIME)	SOCIAL SERVICE (SOC SERV TIME)	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	1,656,895					13.00
14.00	01400	0	0				14.00
15.00	01500	0	0	6,760,363			15.00
16.00	01600	0	0	0	9,123		16.00
17.00	01700	0	0	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	898,447	0	184,979	3,913	0	30.00
31.00	03100	223,734	0	75,370	18	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	31,577	0	1,482	346	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	171,928	0	142,056	1,589	0	50.00
51.00	05100	25,098	0	3,508	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	2,113	0	18,610	0	0	53.00
54.00	05400	14,552	0	16,887	1,069	0	54.00
56.00	05600	0	0	1,409	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	23,716	0	5,682	0	0	59.00
60.00	06000	0	0	0	213	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	0	0	0	0	65.00
66.00	06600	2,154	0	69	10	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	25,732	0	3,551	87	0	69.00
70.00	07000	2,646	0	0	7	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	6,072,039	0	0	73.00
74.00	07400	21,484	0	5,709	0	0	74.00
76.00	03140	0	0	0	0	0	76.00
76.97	07697	1,720	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	5,548	0	2,702	15	0	90.00
91.00	09100	206,446	0	226,181	1,756	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		1,656,895	0	6,760,234	9,023	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07951	0	0	129	100	0	194.00
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B-1

Date/Time Prepared:  
5/25/2016 1:28 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (MED SUPPL COSTS)	PHARMACY (PHARM COSTS)	MEDICAL RECORDS & LIBRARY (MED REC TIME)	SOCIAL SERVICE  (SOC SERV TIME)	
		13.00	14.00	15.00	16.00	17.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	4,738,904	0	4,185,591	2,588,497	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.860111	0.000000	0.619137	283.733092	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	179,585	0	205,914	137,008	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.108386	0.000000	0.030459	15.017867	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B-1  
Date/Time Prepared:  
5/25/2016 1:28 pm

Cost Center Description	INTERNS & RESIDENTS			
	SERVICES-SALARY & FRINGES (HRS)	SERVICES-OTHER PRGM COSTS (HRS)		
	21.00	22.00		
<b>GENERAL SERVICE COST CENTERS</b>				
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00 00500	ADMINISTRATIVE & GENERAL			5.00
7.00 00700	OPERATION OF PLANT			7.00
8.00 00800	LAUNDRY & LINEN SERVICE			8.00
9.00 00900	HOUSEKEEPING			9.00
10.00 01000	DIETARY			10.00
11.00 01100	CAFETERIA			11.00
13.00 01300	NURSING ADMINISTRATION			13.00
14.00 01400	CENTRAL SERVICES & SUPPLY			14.00
15.00 01500	PHARMACY			15.00
16.00 01600	MEDICAL RECORDS & LIBRARY			16.00
17.00 01700	SOCIAL SERVICE			17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 03000	ADULTS & PEDIATRICS	0	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	31.00
32.00 03200	CORONARY CARE UNIT	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
41.00 04100	SUBPROVIDER - IRF	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	42.00
43.00 04300	NURSERY	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000	OPERATING ROOM	0	0	50.00
51.00 05100	RECOVERY ROOM	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00 05600	RADIOISOTOPE	0	0	56.00
57.00 05700	CT SCAN	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000	LABORATORY	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	74.00
76.00 03140	CARDIOLOGY	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800	RURAL HEALTH CLINIC	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00 09000	CLINIC	0	0	90.00
91.00 09100	EMERGENCY	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10 09910	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00 10900	PANCREAS ACQUISITION	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01 19201	NONREIM PARAMED RT	0	0	192.01
194.00 07951	NONREIMBURSABLE COST CENTERS	0	0	194.00
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B-1

Date/Time Prepared:  
5/25/2016 1:28 pm

Cost Center Description		INTERNS & RESIDENTS			
		SERVICES-SALARY & FRINGES (HRS)	SERVICES-OTHER PRGM COSTS (HRS)		
		21.00	22.00		
202.00	Cost to be allocated (per Wkst. B, Part I)	0	0		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/25/2016 1:28 pm	
		Title XVIII	Hospital	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Disallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		39,970,968	0	39,970,968
31.00	03100 INTENSIVE CARE UNIT		11,593,178	0	11,593,178
32.00	03200 CORONARY CARE UNIT		0	0	0
33.00	03300 BURN INTENSIVE CARE UNIT		0	0	0
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0	0	0
41.00	04100 SUBPROVIDER - IRF		0	0	0
42.00	04200 SUBPROVIDER		0	0	0
43.00	04300 NURSERY		1,923,124	0	1,923,124
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM		11,933,049	0	11,933,049
51.00	05100 RECOVERY ROOM		1,062,409	0	1,062,409
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0
53.00	05300 ANESTHESIOLOGY		1,491,746	0	1,491,746
54.00	05400 RADIOLOGY-DIAGNOSTIC		9,537,126	0	9,537,126
56.00	05600 RADIOISOTOPE		650,985	0	650,985
57.00	05700 CT SCAN		0	0	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0
59.00	05900 CARDIAC CATHETERIZATION		1,545,157	0	1,545,157
60.00	06000 LABORATORY		9,216,776	0	9,216,776
60.01	06001 BLOOD LABORATORY		0	0	0
65.00	06500 RESPIRATORY THERAPY	0	2,364,441	0	2,364,441
66.00	06600 PHYSICAL THERAPY	0	2,311,162	0	2,311,162
67.00	06700 OCCUPATIONAL THERAPY	0	383,405	0	383,405
68.00	06800 SPEECH PATHOLOGY	0	166,245	0	166,245
69.00	06900 ELECTROCARDIOLOGY		1,830,983	0	1,830,983
70.00	07000 ELECTROENCEPHALOGRAPHY		120,961	0	120,961
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		10,461,930	0	10,461,930
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		3,775,376	0	3,775,376
73.00	07300 DRUGS CHARGED TO PATIENTS		12,248,588	0	12,248,588
74.00	07400 RENAL DIALYSIS		1,281,006	0	1,281,006
76.00	03140 RADIOLOGY		0	0	0
76.97	07697 CARDIAC REHABILITATION		661,267	0	661,267
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC		0	0	0
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0
90.00	09000 CLINIC		1,226,135	0	1,226,135
91.00	09100 EMERGENCY		12,434,743	0	12,434,743
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		6,315,976	0	6,315,976
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910 CORF		0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900 PANCREAS ACQUISITION		0	0	0
110.00	11000 INTESTINAL ACQUISITION		0	0	0
111.00	11100 ISLET ACQUISITION		0	0	0
200.00	Subtotal (see instructions)	0	144,506,736	0	144,506,736
201.00	Less Observation Beds		6,315,976		6,315,976
202.00	Total (see instructions)	0	138,190,760	0	138,190,760

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet C  
Part I  
Date/Time Prepared:  
5/25/2016 1:28 pm

		Title XVIIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	73,213,345		73,213,345		30.00
31.00	03100	INTENSIVE CARE UNIT	22,369,295		22,369,295		31.00
32.00	03200	CORONARY CARE UNIT	0		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
41.00	04100	SUBPROVIDER - I RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	2,677,365		2,677,365		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	16,638,671	32,245,294	48,883,965	0.244110	50.00
51.00	05100	RECOVERY ROOM	2,394,585	4,352,399	6,746,984	0.157464	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,037,305	3,414,153	6,451,458	0.231226	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,275,398	57,268,036	88,543,434	0.107711	54.00
56.00	05600	RADIOISOTOPE	5,285,226	4,675,736	9,960,962	0.065354	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,902,606	851,109	7,753,715	0.199280	59.00
60.00	06000	LABORATORY	38,383,550	19,757,957	58,141,507	0.158523	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	18,309,992	2,777,133	21,087,125	0.112127	65.00
66.00	06600	PHYSICAL THERAPY	2,520,558	3,245,741	5,766,299	0.400805	66.00
67.00	06700	OCCUPATIONAL THERAPY	839,464	488,894	1,328,358	0.288631	67.00
68.00	06800	SPEECH PATHOLOGY	608,270	155,039	763,309	0.217795	68.00
69.00	06900	ELECTROCARDIOLOGY	9,099,337	6,599,488	15,698,825	0.116632	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	470,214	112,168	582,382	0.207700	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,660,853	2,860,266	7,521,119	1.391007	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,255,680	2,378,492	6,634,172	0.569080	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,379,342	12,355,311	59,734,653	0.205050	73.00
74.00	07400	RENAL DIALYSIS	4,397,348	0	4,397,348	0.291313	74.00
76.00	03140	CARDIOLOGY	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	45,582	951,139	996,721	0.663442	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	1,777,263	1,777,263	0.689901	90.00
91.00	09100	EMERGENCY	20,130,234	60,221,200	80,351,434	0.154754	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	11,108,434	11,108,434	0.568575	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0		99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	314,894,220	227,595,252	542,489,472		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	314,894,220	227,595,252	542,489,472		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/25/2016 1:28 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
32.00	03200 CORONARY CARE UNIT			32.00
33.00	03300 BURN INTENSIVE CARE UNIT			33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100 SUBPROVIDER - I RF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.244110		50.00
51.00	05100 RECOVERY ROOM	0.157464		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.231226		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.107711		54.00
56.00	05600 RADIOISOTOPE	0.065354		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.199280		59.00
60.00	06000 LABORATORY	0.158523		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.112127		65.00
66.00	06600 PHYSICAL THERAPY	0.400805		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.288631		67.00
68.00	06800 SPEECH PATHOLOGY	0.217795		68.00
69.00	06900 ELECTROCARDIOLOGY	0.116632		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.207700		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.391007		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.569080		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.205050		73.00
74.00	07400 RENAL DIALYSIS	0.291313		74.00
76.00	03140 RADIOLOGY	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.663442		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.689901		90.00
91.00	09100 EMERGENCY	0.154754		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.568575		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910 CORF			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/25/2016 1:28 pm
		Title XIX	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		39,970,968	0	39,970,968	30.00
31.00	03100 INTENSIVE CARE UNIT		11,593,178	0	11,593,178	31.00
32.00	03200 CORONARY CARE UNIT		0	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT		0	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0	0	0	34.00
41.00	04100 SUBPROVIDER - IRF		0	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
43.00	04300 NURSERY		1,923,124	0	1,923,124	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		11,933,049	0	11,933,049	50.00
51.00	05100 RECOVERY ROOM		1,062,409	0	1,062,409	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY		1,491,746	0	1,491,746	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		9,537,126	0	9,537,126	54.00
56.00	05600 RADIOISOTOPE		650,985	0	650,985	56.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		1,545,157	0	1,545,157	59.00
60.00	06000 LABORATORY		9,216,776	0	9,216,776	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	2,364,441	0	2,364,441	65.00
66.00	06600 PHYSICAL THERAPY	0	2,311,162	0	2,311,162	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	383,405	0	383,405	67.00
68.00	06800 SPEECH PATHOLOGY	0	166,245	0	166,245	68.00
69.00	06900 ELECTROCARDIOLOGY		1,830,983	0	1,830,983	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		120,961	0	120,961	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		10,461,930	0	10,461,930	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		3,775,376	0	3,775,376	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		12,248,588	0	12,248,588	73.00
74.00	07400 RENAL DIALYSIS		1,281,006	0	1,281,006	74.00
76.00	03140 RADIOLOGY		0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION		661,267	0	661,267	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000 CLINIC		1,226,135	0	1,226,135	90.00
91.00	09100 EMERGENCY		12,434,743	0	12,434,743	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		6,315,976	0	6,315,976	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910 CORF		0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900 PANCREAS ACQUISITION		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION		0	0	0	110.00
111.00	11100 ISLET ACQUISITION		0	0	0	111.00
200.00	Subtotal (see instructions)		144,506,736	0	144,506,736	200.00
201.00	Less Observation Beds		6,315,976	0	6,315,976	201.00
202.00	Total (see instructions)		138,190,760	0	138,190,760	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140048		Period: From 01/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 5/25/2016 1:28 pm	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	73,213,345		73,213,345			30.00
31.00	03100	INTENSIVE CARE UNIT	22,369,295		22,369,295			31.00
32.00	03200	CORONARY CARE UNIT	0		0			32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
41.00	04100	SUBPROVIDER - I RF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	2,677,365		2,677,365			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	16,638,671	32,245,294	48,883,965	0.244110	0.000000	50.00
51.00	05100	RECOVERY ROOM	2,394,585	4,352,399	6,746,984	0.157464	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,037,305	3,414,153	6,451,458	0.231226	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,275,398	57,268,036	88,543,434	0.107711	0.000000	54.00
56.00	05600	RADIOISOTOPE	5,285,226	4,675,736	9,960,962	0.065354	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,902,606	851,109	7,753,715	0.199280	0.000000	59.00
60.00	06000	LABORATORY	38,383,550	19,757,957	58,141,507	0.158523	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	18,309,992	2,777,133	21,087,125	0.112127	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,520,558	3,245,741	5,766,299	0.400805	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	839,464	488,894	1,328,358	0.288631	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	608,270	155,039	763,309	0.217795	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	9,099,337	6,599,488	15,698,825	0.116632	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	470,214	112,168	582,382	0.207700	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,660,853	2,860,266	7,521,119	1.391007	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,255,680	2,378,492	6,634,172	0.569080	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,379,342	12,355,311	59,734,653	0.205050	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,397,348	0	4,397,348	0.291313	0.000000	74.00
76.00	03140	CARDIOLOGY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	45,582	951,139	996,721	0.663442	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	1,777,263	1,777,263	0.689901	0.000000	90.00
91.00	09100	EMERGENCY	20,130,234	60,221,200	80,351,434	0.154754	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	11,108,434	11,108,434	0.568575	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
200.00		Subtotal (see instructions)	314,894,220	227,595,252	542,489,472			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	314,894,220	227,595,252	542,489,472			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/25/2016 1:28 pm
			Title XIX	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio		
INPATIENT ROUTINE SERVICE COST CENTERS			11.00		
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
32.00	03200	CORONARY CARE UNIT			32.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100	SUBPROVIDER - I RF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03140	CARDIOLOGY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
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: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part I Date/Time Prepared: 5/25/2016 1:28 pm
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Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,276,924	0	3,276,924	34,959	93.74	30.00
31.00	INTENSIVE CARE UNIT	854,527		854,527	7,358	116.14	31.00
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	114,468		114,468	2,995	38.22	43.00
200.00	Total (Lines 30-199)	4,245,919		4,245,919	45,312		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	9,667	906,185				30.00
31.00	INTENSIVE CARE UNIT	2,534	294,299				31.00
32.00	CORONARY CARE UNIT	0	0				32.00
33.00	BURN INTENSIVE CARE UNIT	0	0				33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0				34.00
41.00	SUBPROVIDER - IRF	0	0				41.00
42.00	SUBPROVIDER	0	0				42.00
43.00	NURSERY	0	0				43.00
200.00	Total (Lines 30-199)	12,201	1,200,484				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 5/25/2016 1:28 pm
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Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,293,190	48,883,965	0.026454	4,910,882	129,912	50.00
51.00	05100	RECOVERY ROOM	16,437	6,746,984	0.002436	620,431	1,511	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	12,079	6,451,458	0.001872	582,293	1,090	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	728,064	88,543,434	0.008223	10,689,428	87,899	54.00
56.00	05600	RADIOISOTOPE	52,340	9,960,962	0.005255	1,991,349	10,465	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	55,996	7,753,715	0.007222	1,946,299	14,056	59.00
60.00	06000	LABORATORY	311,799	58,141,507	0.005363	12,419,655	66,607	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	120,237	21,087,125	0.005702	7,140,807	40,717	65.00
66.00	06600	PHYSICAL THERAPY	237,289	5,766,299	0.041151	967,274	39,804	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,621	1,328,358	0.016276	336,587	5,478	67.00
68.00	06800	SPEECH PATHOLOGY	7,413	763,309	0.009712	251,767	2,445	68.00
69.00	06900	ELECTROCARDIOLOGY	161,472	15,698,825	0.010286	3,252,471	33,455	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,421	582,382	0.011025	198,797	2,192	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,348	7,521,119	0.010284	1,458,087	14,995	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	27,905	6,634,172	0.004206	1,242,374	5,225	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	247,695	59,734,653	0.004147	15,588,498	64,646	73.00
74.00	07400	RENAL DIALYSIS	44,170	4,397,348	0.010045	2,002,547	20,116	74.00
76.00	03140	CARDIOLOGY	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	103,237	996,721	0.103577	11,363	1,177	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	84,821	1,777,263	0.047726	0	0	90.00
91.00	09100	EMERGENCY	790,607	80,351,434	0.009839	6,728,288	66,200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	517,803	11,108,434	0.046614	0	0	92.00
200.00		Total (lines 50-199)	4,917,944	444,229,467		72,339,197	607,990	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part III Date/Time Prepared: 5/25/2016 1:28 pm
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Cost Center Description			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	0		31.00	
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0		32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0		33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0		34.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0		41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	0		42.00	
43.00	04300	NURSERY	0	0	0	0	0		43.00	
200.00		Total (lines 30-199)	0	0	0	0	0		200.00	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)				
			6.00	7.00	8.00	9.00				
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	34,959	0.00	9,667	0			30.00	
31.00	03100	INTENSIVE CARE UNIT	7,358	0.00	2,534	0			31.00	
32.00	03200	CORONARY CARE UNIT	0	0.00	0	0			32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0.00	0	0			33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0.00	0	0			34.00	
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0			41.00	
42.00	04200	SUBPROVIDER	0	0.00	0	0			42.00	
43.00	04300	NURSERY	2,995	0.00	0	0			43.00	
200.00		Total (lines 30-199)	45,312		12,201	0			200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 1:28 pm
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Cost Center Description		Title XVIII				Hospital		PPS
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00	
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00	
57.00	05700	CT SCAN	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	0	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00	
76.00	03140	CARDIOLOGY	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00	
90.00	09000	CLINIC	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00	
200.00		Total (lines 50-199)	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet D  
Part IV  
Date/Time Prepared:  
5/25/2016 1:28 pm

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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	48,883,965	0.000000	0.000000	4,910,882	50.00
51.00	05100	RECOVERY ROOM	0	6,746,984	0.000000	0.000000	620,431	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	6,451,458	0.000000	0.000000	582,293	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	88,543,434	0.000000	0.000000	10,689,428	54.00
56.00	05600	RADIOISOTOPE	0	9,960,962	0.000000	0.000000	1,991,349	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	7,753,715	0.000000	0.000000	1,946,299	59.00
60.00	06000	LABORATORY	0	58,141,507	0.000000	0.000000	12,419,655	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	21,087,125	0.000000	0.000000	7,140,807	65.00
66.00	06600	PHYSICAL THERAPY	0	5,766,299	0.000000	0.000000	967,274	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,328,358	0.000000	0.000000	336,587	67.00
68.00	06800	SPEECH PATHOLOGY	0	763,309	0.000000	0.000000	251,767	68.00
69.00	06900	ELECTROCARDIOLOGY	0	15,698,825	0.000000	0.000000	3,252,471	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	582,382	0.000000	0.000000	198,797	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,521,119	0.000000	0.000000	1,458,087	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,634,172	0.000000	0.000000	1,242,374	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	59,734,653	0.000000	0.000000	15,588,498	73.00
74.00	07400	RENAL DIALYSIS	0	4,397,348	0.000000	0.000000	2,002,547	74.00
76.00	03140	CARDIOLOGY	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	996,721	0.000000	0.000000	11,363	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	1,777,263	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	80,351,434	0.000000	0.000000	6,728,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	11,108,434	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	444,229,467			72,339,197	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 1:28 pm
Title XVIII		Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	4,726,614	0	50.00
51.00	05100 RECOVERY ROOM	0	617,456	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	529,394	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	8,450,548	0	54.00
56.00	05600 RADIOISOTOPE	0	1,270,144	0	56.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	275,572	0	59.00
60.00	06000 LABORATORY	0	2,407,792	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	462,724	0	65.00
66.00	06600 PHYSICAL THERAPY	0	30,537	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	125	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,717	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,336,786	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	24,693	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	577,986	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	426,844	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,223,549	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03140 RADIOLOGY	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	208,597	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	538,263	0	90.00
91.00	09100 EMERGENCY	0	6,394,015	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,468,242	0	92.00
200.00	Total (lines 50-199)	0	32,971,598	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/25/2016 1:28 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.244110	4,726,614	0	0	1,153,814	50.00
51.00	05100 RECOVERY ROOM	0.157464	617,456	0	0	97,227	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.231226	529,394	0	0	122,410	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.107711	8,450,548	0	0	910,217	54.00
56.00	05600 RADIOISOTOPE	0.065354	1,270,144	0	0	83,009	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.199280	275,572	0	0	54,916	59.00
60.00	06000 LABORATORY	0.158523	2,407,792	0	0	381,690	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.112127	462,724	0	0	51,884	65.00
66.00	06600 PHYSICAL THERAPY	0.400805	30,537	0	0	12,239	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.288631	125	0	0	36	67.00
68.00	06800 SPEECH PATHOLOGY	0.217795	1,717	0	0	374	68.00
69.00	06900 ELECTROCARDIOLOGY	0.116632	1,336,786	0	0	155,912	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.207700	24,693	0	0	5,129	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.391007	577,986	0	0	803,983	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.569080	426,844	0	0	242,908	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.205050	2,223,549	0	27,273	455,939	73.00
74.00	07400 RENAL DIALYSIS	0.291313	0	0	0	0	74.00
76.00	03140 RADIOLOGY	0.000000	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.663442	208,597	0	0	138,392	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000 CLINIC	0.689901	538,263	0	0	371,348	90.00
91.00	09100 EMERGENCY	0.154754	6,394,015	0	0	989,499	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.568575	2,468,242	0	0	1,403,381	92.00
200.00	Subtotal (see instructions)		32,971,598	0	27,273	7,434,307	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		32,971,598	0	27,273	7,434,307	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/25/2016 1:28 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	5,592		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03140 RADIOLOGY	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	0	5,592		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	5,592		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/25/2016 1:28 pm
		Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.244110	0	0	1,396,799	0
51.00 05100 RECOVERY ROOM	0.157464	0	0	229,041	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.231226	0	0	184,534	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.107711	0	0	7,330,331	0
56.00 05600 RADIOISOTOPE	0.065354	0	0	421,630	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.199280	0	0	50,327	0
60.00 06000 LABORATORY	0.158523	0	0	3,013,214	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.112127	0	0	404,256	0
66.00 06600 PHYSICAL THERAPY	0.400805	0	0	238,977	0
67.00 06700 OCCUPATIONAL THERAPY	0.288631	0	0	29,676	0
68.00 06800 SPEECH PATHOLOGY	0.217795	0	0	2,714	0
69.00 06900 ELECTROCARDIOLOGY	0.116632	0	0	770,146	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.207700	0	0	11,641	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.391007	0	0	95,380	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.569080	0	0	45,634	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.205050	0	0	1,247,740	0
74.00 07400 RENAL DIALYSIS	0.291313	0	0	0	0
76.00 03140 RADIOLOGY	0.000000	0	0	0	0
76.97 07697 CARDIAC REHABILITATION	0.663442	0	0	11,141	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
90.00 09000 CLINIC	0.689901	0	0	166,436	0
91.00 09100 EMERGENCY	0.154754	0	0	12,399,727	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.568575	0	0	1,598,098	0
200.00 Subtotal (see instructions)		0	0	29,647,442	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	29,647,442	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/25/2016 1:28 pm
		Title XIX	Hospital	Cost

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	340,973	50.00
51.00	05100	RECOVERY ROOM	0	36,066	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	42,669	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	789,557	54.00
56.00	05600	RADIOISOTOPE	0	27,555	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	10,029	59.00
60.00	06000	LABORATORY	0	477,664	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	45,328	65.00
66.00	06600	PHYSICAL THERAPY	0	95,783	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,565	67.00
68.00	06800	SPEECH PATHOLOGY	0	591	68.00
69.00	06900	ELECTROCARDIOLOGY	0	89,824	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,418	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	132,674	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	25,969	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	255,849	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03140	CARDIOLOGY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	7,391	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	114,824	90.00
91.00	09100	EMERGENCY	0	1,918,907	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	908,639	92.00
200.00		Subtotal (see instructions)	0	5,331,275	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	5,331,275	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/25/2016 1:28 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		34,959	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		34,959	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)		29,435	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)		9,667	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
<b>SWING BED ADJUSTMENT</b>				
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)		39,970,968	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)		39,970,968	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		39,970,968	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,143.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		11,052,958	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)		11,052,958	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140048		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
		Title XVIII		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	11,593,178	7,358	1,575.59	2,534	3,992,545	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					14,394,060	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					29,439,563	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,200,484	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					607,990	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,808,474	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					27,631,089	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)					5,524	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,143.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					6,315,976	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140048		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/25/2016 1:28 pm	
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	3,276,924	39,970,968	0.081983	6,315,976	517,803	90.00
91.00	Nursing School cost	0	39,970,968	0.000000	6,315,976	0	91.00
92.00	Allied health cost	0	39,970,968	0.000000	6,315,976	0	92.00
93.00	All other Medical Education	0	39,970,968	0.000000	6,315,976	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XIX		Hospital
				Date/Time Prepared: 5/25/2016 1:28 pm
Cost Center Description				Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		34,959	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		34,959	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)		29,435	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		8,662	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)		2,995	15.00
16.00	Nursery days (title V or XIX only)		2,782	16.00
<b>SWING BED ADJUSTMENT</b>				
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)		39,970,968	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)		39,970,968	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		39,970,968	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,143.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,903,871	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)		9,903,871	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140048		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
Title XIX		Hospital		Cost			
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	1,923,124	2,995	642.11	2,782	1,786,350		42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	11,593,178	7,358	1,575.59	2,165	3,411,152		43.00
44.00 CORONARY CARE UNIT	0	0	0.00	0	0		44.00
45.00 BURN INTENSIVE CARE UNIT	0	0	0.00	0	0		45.00
46.00 SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0		46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,856,275		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					18,957,648		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
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
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					5,524		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,143.37		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					6,315,976		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140048		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/25/2016 1:28 pm	
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	3,276,924	39,970,968	0.081983	6,315,976	517,803	90.00
91.00	Nursing School cost	0	39,970,968	0.000000	6,315,976	0	91.00
92.00	Allied health cost	0	39,970,968	0.000000	6,315,976	0	92.00
93.00	All other Medical Education	0	39,970,968	0.000000	6,315,976	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/25/2016 1:28 pm	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		19,531,849	30.00
31.00	03100	INTENSIVE CARE UNIT		7,353,427	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.244110	4,910,882	50.00
51.00	05100	RECOVERY ROOM	0.157464	620,431	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.231226	582,293	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107711	10,689,428	54.00
56.00	05600	RADIOISOTOPE	0.065354	1,991,349	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.199280	1,946,299	59.00
60.00	06000	LABORATORY	0.158523	12,419,655	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.112127	7,140,807	65.00
66.00	06600	PHYSICAL THERAPY	0.400805	967,274	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.288631	336,587	67.00
68.00	06800	SPEECH PATHOLOGY	0.217795	251,767	68.00
69.00	06900	ELECTROCARDIOLOGY	0.116632	3,252,471	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.207700	198,797	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.391007	1,458,087	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.569080	1,242,374	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205050	15,588,498	73.00
74.00	07400	RENAL DIALYSIS	0.291313	2,002,547	74.00
76.00	03140	CARDIOLOGY	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.663442	11,363	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.689901	0	90.00
91.00	09100	EMERGENCY	0.154754	6,728,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.568575	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		72,339,197	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)		72,339,197	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/25/2016 1:28 pm	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		10,455,559	30.00
31.00	03100	INTENSIVE CARE UNIT		1,894,161	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		1,573,733	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.244110	1,358,186	50.00
51.00	05100	RECOVERY ROOM	0.157464	194,612	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.231226	482,630	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107711	2,609,232	54.00
56.00	05600	RADIOISOTOPE	0.065354	366,949	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.199280	462,392	59.00
60.00	06000	LABORATORY	0.158523	4,567,704	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.112127	1,649,601	65.00
66.00	06600	PHYSICAL THERAPY	0.400805	138,444	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.288631	36,748	67.00
68.00	06800	SPEECH PATHOLOGY	0.217795	29,706	68.00
69.00	06900	ELECTROCARDIOLOGY	0.116632	758,102	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.207700	36,228	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.391007	299,464	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.569080	130,128	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205050	5,055,883	73.00
74.00	07400	RENAL DIALYSIS	0.291313	200,657	74.00
76.00	03140	CARDIOLOGY	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.663442	3,852	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.689901	0	90.00
91.00	09100	EMERGENCY	0.154754	2,064,096	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.568575	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		20,444,614	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)		20,444,614	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/25/2016 1:28 pm
		Title XVIII	Hospital	PPS
		0	1.00	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
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)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		19,967,555	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)		534,478	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		175.87	4.00
<b>Indirect Medical Education Adjustment</b>				
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)		1.02	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.02	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).		-1.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		14.96	30.00
31.00	Percentage of Medicaid patient days (see instructions)		34.69	31.00
32.00	Sum of lines 30 and 31		49.65	32.00
33.00	Allowable disproportionate share percentage (see instructions)		30.18	33.00
34.00	Disproportionate share adjustment (see instructions)		1,506,552	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/25/2016 1:28 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			1.00	2.00	
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)		0.000452355	0.000451901	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		3,459,450	2,894,946	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		2,587,478	727,691	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		3,315,169		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		25,323,754		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)		25,323,754		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,786,032		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		27,109,786		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		27,109,786		61.00
62.00	Deductibles billed to program beneficiaries		2,266,856		62.00
63.00	Coinurance billed to program beneficiaries		90,720		63.00
64.00	Allowable bad debts (see instructions)		1,433,362		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		931,685		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		818,835		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		25,683,895		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)		-59,892		70.93
70.94	HRR adjustment amount (see instructions)		-229,199		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/25/2016 1:28 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 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)		25,394,804		71.00
71.01	Sequestration adjustment (see instructions)		507,896		71.01
72.00	Interim payments		23,941,248		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)		945,660		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		227,690		75.00
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 1.00	On/After 10/1 2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/25/2016 1:28 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			5,592 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			7,434,307 2.00
3.00	PPS payments			5,770,519 3.00
4.00	Outlier payment (see instructions)			4,043 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.820 5.00
6.00	Line 2 times line 5			6,096,132 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			94.73 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)			5,592 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			27,273 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)			27,273 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			27,273 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			21,681 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)			5,592 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			5,774,562 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			1,215,561 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)			4,564,593 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			4,564,593 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			4,564,593 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			594,217 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			386,241 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			404,914 36.00
37.00	Subtotal (see instructions)			4,950,834 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			4,950,834 40.00
40.01	Sequestration adjustment (see instructions)			99,017 40.01
41.00	Interim payments			4,456,740 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			395,077 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 140048		Period: From 01/01/2015 To 12/31/2015		Worksheet E-1 Part I Date/Time Prepared: 5/25/2016 1:28 pm	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		23,989,187		4,467,929		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	08/11/2015	47,939	08/11/2015	11,189		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)		-47,939		-11,189		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)		23,941,248		4,456,740		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		945,660		395,077		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		24,886,908		4,851,817		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: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/25/2016 1:28 pm
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		9,282	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		12,201	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		6,833	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		36,793	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		542,489,472	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		7,731,000	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		0	8.00
9.00	Sequestration adjustment amount (see instructions)		0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		0	10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		0	32.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet E-4 Date/Time Prepared: 5/25/2016 1:28 pm	
		Title XVII I	Hospital	PPS	
				1.00	
<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	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			0.00	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)			0.00	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)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	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	0.00	0.00	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	0.00	0.00	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	0.00		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	0.00		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	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
19.00	Approved amount for resident costs	0	0	0	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)			0	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>					
26.00	Inpatient Days (see instructions)	12,201	6,833		26.00
27.00	Total Inpatient Days (see instructions)	37,134	37,134		27.00
28.00	Ratio of inpatient days to total inpatient days	0.328567	0.184009		28.00
29.00	Program direct GME amount	0	0		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		0		30.00
31.00	Net Program direct GME amount			0	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet E-4 Date/Time Prepared: 5/25/2016 1:28 pm
		Title XVIII	Hospital	PPS
				1.00
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)</b>				
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)		4,397,348	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
<b>APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY</b>				
<b>Part A Reasonable Cost</b>				
37.00	Reasonable cost (see instructions)		29,439,563	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)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		29,439,563	41.00
<b>Part B Reasonable Cost</b>				
42.00	Reasonable cost (see instructions)		7,439,899	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		7,439,899	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		36,879,462	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.798264	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.201736	47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48.00	Total program GME payment (line 31)		0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		0	50.00

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

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet G

Date/Time Prepared:  
5/25/2016 1:28 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	120,549,000	0	0	0	1.00
2.00	Temporary investments	81,893,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	518,635,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	172,222,000	0	0	0	9.00
10.00	Due from other funds	28,283,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	921,582,000	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	121,391,000	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	2,664,476,000	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	1,309,817,000	0	0	0	23.00
24.00	Accumulated depreciation	-2,158,727,000	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)	1,936,957,000	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	4,096,861,000	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	352,448,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,449,309,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	7,307,848,000	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	314,213,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	344,980,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	70,871,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	460,696,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,190,760,000	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	1,501,836,000	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	936,798,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,438,634,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,629,394,000	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	3,678,454,000				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)	3,678,454,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	7,307,848,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet G-1

Date/Time Prepared:  
5/25/2016 1:28 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		3,677,605,675		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		848,325			2.00
3.00	Total (sum of line 1 and line 2)		3,678,454,000		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		3,678,454,000		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,678,454,000		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			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: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/25/2016 1:28 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	73,213,345		73,213,345	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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)	73,213,345		73,213,345	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	22,369,295		22,369,295	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	22,369,295		22,369,295	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	95,582,640		95,582,640	17.00
18.00	Ancillary services	196,503,981	154,488,355	350,992,336	18.00
19.00	Outpatient services	20,130,234	74,198,032	94,328,266	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
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	2,677,365	0	2,677,365	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	314,894,220	228,686,387	543,580,607	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		155,884,955		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	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)		155,884,955		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140048

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet G-3

Date/Time Prepared:  
5/25/2016 1:28 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	543,580,607	1.00
2.00	Less contractual allowances and discounts on patients' accounts	388,192,476	2.00
3.00	Net patient revenues (line 1 minus line 2)	155,388,131	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	155,884,955	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-496,824	5.00
<b>OTHER INCOME</b>			
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	INTERCOMPANY/ MISC INCOME	1,406,218	24.00
25.00	Total other income (sum of lines 6-24)	1,406,218	25.00
26.00	Total (line 5 plus line 25)	909,394	26.00
27.00	NET NON OPERATING INCOME	61,069	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	61,069	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	848,325	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet I-5 Date/Time Prepared: 5/25/2016 1:28 pm
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		1.00	2.00	
<b>PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B</b>				
1.00	Total expenses related to care of program beneficiaries (see instructions)	0		1.00
2.00	Total payment due (from Wkst. 1-4, col. 6, line 11) (see instructions)	0	0	2.00
2.01	Total payment due (from Wkst. 1-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	0	0	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	0	0	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012	0	0	5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013	0	0	5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014	0	0	5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Total bad debts (sum of line 5 through line 5.04)	0	0	5.05
6.00	Allowable bad debts (see instructions)	0		6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	8.00
9.00	Program payment (see instructions)	0	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
<b>PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE</b>				
12.00	Total allowable expenses (see instructions)	0		12.00
13.00	Total composite costs (from Wkst. 1-4, col. 2, line 11)	0		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	0.000000		14.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140048	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/25/2016 1:28 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,597,742	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		19,409	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)		101.74	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		14.96	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		34.69	8.00
9.00	Sum of lines 7 and 8		49.65	9.00
10.00	Allowable disproportionate share percentage (see instructions)		10.57	10.00
11.00	Disproportionate share adjustment (see instructions)		168,881	11.00
12.00	Total prospective capital payments (see instructions)		1,786,032	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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