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: 140100	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/25/2015 1:03 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/25/2015 Time: 1:03 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MIDWESTERN REGIONAL MEDICAL CENTER (140100) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-11,596	-95,171	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-11,596	-95,171	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2015 12:12 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2501 EMMAUS AVENUE	PO Box:			1.00
2.00	City: ZION	State: IL	Zip Code: 60099	County: LAKE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	MIDWESTERN REGIONAL MEDICAL CENTER	140100	29404	1	07/01/1967	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2014	06/30/2015	20.00
21.00	Type of Control (see instructions)	4		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.	N	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	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0	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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2015 12:12 pm

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				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)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2015 12:12 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2015 12:12 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2015 12:12 pm

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	3,673,362	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2015 12:12 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	14H130	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: CANCER TREATMENT CENTERS OF AMERICA	Contractor's Name: NGS	Contractor's Number: 00131	141.00
142.00	Street: 1336 BASSWOOD ROAD	PO Box: 6775 W WA		142.00
143.00	City: SCHAUMBURG, IL 60173	State: IL	Zip Code: 53214	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140100	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/20/2015 12:12 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: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2015 12:12 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	10/28/2015	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00

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

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

			Part A		Part B	
		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)		Y	11/04/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
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: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2015 12:12 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				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				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				Y	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
	Interest Expense					
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
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				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
	Provider-Based Physicians					
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	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	COREY	RUTLEDGE	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	612-376-4500	COREY.RUTLEDGE@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2015 12:12 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	11/04/2015			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)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		PRINCIPAL		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: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/20/2015 12:12 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	53	19,345	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)		53	19,345	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	12	4,380	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		73	26,645	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		73				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: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2015 12:12 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	714	10	8,005			1.00
2.00	HMO and other (see instructions)	129	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)	714	10	8,005			7.00
8.00	INTENSIVE CARE UNIT	75	0	1,505			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	161	1	2,191			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	950	11	11,701	0.00	1,269.39	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	1,269.39	27.00
28.00	Observation Bed Days		2	1,132			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2015 12:12 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	181	7	2,091	1.00
2.00	HMO and other (see instructions)			0	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	181	7	2,091	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 11/20/2015 12:12 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	80,224,747	0	80,224,747	2,640,336.18	30.38	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)		7,891,353	366,267	8,257,620	328,505.12	25.14	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,048,070	0	3,048,070	30,512.75	99.89	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		190,240	0	190,240	3,160.00	60.20	13.00
14.00	Home office salaries & wage-related costs		28,671,703	0	28,671,703	324,976.00	88.23	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		24,414,988	0	24,414,988			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		3,469,306	0	3,469,306			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	5,410,001	-4,102,863	1,307,138	28,352.42	46.10	26.00
27.00	Administrative & General	5.00	7,545,187	1,400,328	8,945,515	289,843.31	30.86	27.00
28.00	Administrative & General under contract (see inst.)		563,162	0	563,162	1,606.27	350.60	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,608,085	61,647	1,669,732	64,457.23	25.90	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,399,045	53,633	1,452,678	96,508.28	15.05	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,064,992	-1,754,613	310,379	19,425.32	15.98	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,833,776	1,833,776	114,768.43	15.98	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,248,499	107,832	1,356,331	33,768.62	40.17	38.00
39.00	Central Services and Supply	14.00	509,454	19,530	528,984	24,733.01	21.39	39.00
40.00	Pharmacy	15.00	3,000,451	115,024	3,115,475	82,972.87	37.55	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 11/20/2015 12:12 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	2,811,692	107,788	2,919,480	107,142.17	27.25	41.00
42.00	Social Service	17.00	796,085	30,518	826,603	31,658.51	26.11	42.00
43.00	Other General Service	18.00	7,383,849	283,064	7,666,913	219,858.13	34.87	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 11/20/2015 12:12 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		80,787,909	0	80,787,909	2,641,942.45	30.58	1.00
2.00	Excluded area salaries (see instructions)		7,891,353	366,267	8,257,620	328,505.12	25.14	2.00
3.00	Subtotal salaries (line 1 minus line 2)		72,896,556	-366,267	72,530,289	2,313,437.33	31.35	3.00
4.00	Subtotal other wages & related costs (see inst.)		31,910,013	0	31,910,013	358,648.75	88.97	4.00
5.00	Subtotal wage-related costs (see inst.)		24,414,988	0	24,414,988	0.00	33.66	5.00
6.00	Total (sum of lines 3 thru 5)		129,221,557	-366,267	128,855,290	2,672,086.08	48.22	6.00
7.00	Total overhead cost (see instructions)		34,340,502	-1,844,336	32,496,166	1,115,094.57	29.14	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part IV Date/Time Prepared: 11/20/2015 12:12 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,977,243	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	12,592,974	8.00
9.00	Prescription Drug Plan	3,017,083	9.00
10.00	Dental, Hearing and Vision Plan	1,310,947	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	171,945	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	630,312	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	1,133,543	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	12,942	14.00
15.00	'Workers' Compensation Insurance	482,135	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	5,452,321	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	496,838	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	606,011	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	27,884,294	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part V Date/Time Prepared: 11/20/2015 12:12 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-10 | Date/Time Prepared: 11/20/2015 12:12 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.238317	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	270,889	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	1,911,755	6.00
7.00	Medicaid cost (line 1 times line 6)	455,604	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)	184,715	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	184,715	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	703,484	28,057,367	28,760,851	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	167,652	6,686,548	6,854,200	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	167,652	6,686,548	6,854,200	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	18,549,019	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	96,655	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	18,452,364	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	4,397,512	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	11,251,712	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	11,436,427	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/20/2015 12:12 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		14,581,743	14,581,743	-205,993	14,375,750	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		11,977,042	11,977,042	0	11,977,042	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,410,001	19,721,547	25,131,548	-3,372,603	21,758,945	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,545,187	337,958,808	345,503,995	229,519	345,733,514	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,608,085	6,265,367	7,873,452	61,647	7,935,099	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	176,630	176,630	0	176,630	8.00
9.00	00900	HOUSEKEEPING	1,399,045	1,010,167	2,409,212	53,633	2,462,845	9.00
10.00	01000	DIETARY	2,064,992	4,115,594	6,180,586	-5,274,451	906,135	10.00
11.00	01100	CAFETERIA	0	0	0	5,353,614	5,353,614	11.00
13.00	01300	NURSING ADMINISTRATION	1,248,499	414,969	1,663,468	107,832	1,771,300	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	509,454	560,024	1,069,478	19,530	1,089,008	14.00
15.00	01500	PHARMACY	3,000,451	587,349	3,587,800	115,024	3,702,824	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,811,692	546,745	3,358,437	107,788	3,466,225	16.00
17.00	01700	SOCIAL SERVICE	796,085	393,958	1,190,043	30,518	1,220,561	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	7,383,849	1,742,812	9,126,661	283,064	9,409,725	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,326,512	1,624,306	8,950,818	280,866	9,231,684	30.00
31.00	03100	INTENSIVE CARE UNIT	1,905,279	361,597	2,266,876	73,040	2,339,916	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,501,272	359,081	2,860,353	95,888	2,956,241	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,112,562	2,523,288	6,635,850	157,657	6,793,507	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,299,712	1,731,354	5,031,066	126,496	5,157,562	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,214,236	3,547,402	5,761,638	84,884	5,846,522	55.00
56.00	05600	RADIOISOTOPE	426,020	238,434	664,454	16,332	680,786	56.00
57.00	05700	CT SCAN	552,842	238,559	791,401	21,194	812,595	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	452,355	449,442	901,797	17,341	919,138	58.00
60.00	06000	LABORATORY	3,000,740	6,763,690	9,764,430	115,035	9,879,465	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,431,832	1,431,832	0	1,431,832	63.00
64.00	06400	INTRAVENOUS THERAPY	2,136,100	344,510	2,480,610	81,889	2,562,499	64.00
65.00	06500	RESPIRATORY THERAPY	874,709	324,971	1,199,680	33,532	1,233,212	65.00
66.00	06600	PHYSICAL THERAPY	1,366,848	303,486	1,670,334	52,399	1,722,733	66.00
69.00	06900	ELECTROCARDIOLOGY	398,608	106,025	504,633	15,281	519,914	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,875,576	16,875,576	0	16,875,576	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	87,767,177	87,767,177	0	87,767,177	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	937,265	195,890	1,133,155	35,931	1,169,086	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,937,071	1,239,603	7,176,674	227,601	7,404,275	90.00
91.00	09100	EMERGENCY	1,113,923	1,222,845	2,336,768	42,703	2,379,471	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		536,085	536,085	-351,090	184,995	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	72,333,394	528,237,908	600,571,302	-1,363,899	599,207,403	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-2,612	82,220	79,608	-100	79,508	190.00
191.00	19100	RESEARCH	545,098	137,982	683,080	20,897	703,977	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	7,348,867	38,633,613	45,982,480	1,343,102	47,325,582	194.00
200.00		TOTAL (SUM OF LINES 118-199)	80,224,747	567,091,723	647,316,470	0	647,316,470	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/20/2015 12:12 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-5,638,556	8,737,194		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,678,416	13,655,458		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-248,218	21,510,727		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-278,577,516	67,155,998		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	7,935,099		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	176,630		8.00
9.00	00900	HOUSEKEEPING	-45,891	2,416,954		9.00
10.00	01000	DIETARY	-462	905,673		10.00
11.00	01100	CAFETERIA	-4,056,114	1,297,500		11.00
13.00	01300	NURSING ADMINISTRATION	-20	1,771,280		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-12	1,088,996		14.00
15.00	01500	PHARMACY	21	3,702,845		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,977	3,462,248		16.00
17.00	01700	SOCIAL SERVICE	-87,378	1,133,183		17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	-142,788	9,266,937		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-68	9,231,616		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,339,916		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-27	2,956,214		34.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	6,793,507		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-41	5,157,521		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-14,684	5,831,838		55.00
56.00	05600	RADIOISOTOPE	0	680,786		56.00
57.00	05700	CT SCAN	0	812,595		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-1,670	917,468		58.00
60.00	06000	LABORATORY	0	9,879,465		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,431,832		63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,562,499		64.00
65.00	06500	RESPIRATORY THERAPY	-173	1,233,039		65.00
66.00	06600	PHYSICAL THERAPY	-92	1,722,641		66.00
69.00	06900	ELECTROCARDIOLOGY	0	519,914		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,875,576		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	87,767,177		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	-57	1,169,029		76.01
76.02	03952	PAIN MANAGEMENT	0	0		76.02
76.03	03954	INFUSION CENTER	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-71	7,404,204		90.00
91.00	09100	EMERGENCY	-864,508	1,514,963		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-184,995	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-288,188,881	311,018,522		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	79,508		190.00
191.00	19100	RESEARCH	0	703,977		191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	47,325,582		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-288,188,881	359,127,589		200.00

RECLASSIFICATIONS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/20/2015 12:12 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS CAFETERIA					
1.00	CAFETERIA	11.00	1,833,776	3,519,838		1.00
	0		1,833,776	3,519,838		
	B - EMPLOYEE BONUS					
1.00	ADMINISTRATIVE & GENERAL	5.00	1,395,836	0		1.00
2.00	OPERATION OF PLANT	7.00	61,647	0		2.00
3.00	HOUSEKEEPING	9.00	53,633	0		3.00
4.00	DIETARY	10.00	79,163	0		4.00
5.00	NURSING ADMINISTRATION	13.00	107,832	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	19,530	0		6.00
7.00	PHARMACY	15.00	115,024	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	107,788	0		8.00
9.00	SOCIAL SERVICE	17.00	30,518	0		9.00
10.00	OTHER GENERAL SERVICE (SPECIFY)	18.00	283,064	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	280,866	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	73,040	0		12.00
13.00	SURGICAL INTENSIVE CARE UNIT	34.00	95,888	0		13.00
14.00	OPERATING ROOM	50.00	157,657	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	126,496	0		15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	84,884	0		16.00
17.00	RADIOISOTOPE	56.00	16,332	0		17.00
18.00	CT SCAN	57.00	21,194	0		18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	17,341	0		19.00
20.00	LABORATORY	60.00	115,035	0		20.00
22.00	INTRAVENOUS THERAPY	64.00	81,889	0		22.00
23.00	RESPIRATORY THERAPY	65.00	33,532	0		23.00
24.00	PHYSICAL THERAPY	66.00	52,399	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	15,281	0		25.00
26.00	HOSPITAL NUTRITION	76.01	35,931	0		26.00
28.00	CLINIC	90.00	227,601	0		28.00
29.00	EMERGENCY	91.00	42,703	0		29.00
30.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	-100	0		30.00
31.00	RESEARCH	191.00	20,897	0		31.00
32.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	349,962	0		32.00
	0		4,102,863	0		
	C - PROPERTY TAX					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	1,090,741		1.00
	0		0	1,090,741		
	D - TRAVEL/SCHEDULING					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	79,739	7,645		1.00
	0		79,739	7,645		
	E - GUEST SERVICES					
1.00		0.00	0	0		1.00
	0		0	0		
	F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	351,090		1.00
	0		0	351,090		
	G - INSURANCE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	533,658		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	730,260		2.00
	0		0	1,263,918		
	H - TRANSPORTATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	84,231	100,754		1.00
	0		84,231	100,754		
500.00	Grand Total: Increases		6,100,609	6,333,986		500.00

RECLASSIFICATIONS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/20/2015 12:12 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA						
1.00	DIETARY	10.00	1,833,776	3,519,838	0		1.00
	0		1,833,776	3,519,838			
	B - EMPLOYEE BONUS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	4,102,863	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
	0		4,102,863	0			
	C - PROPERTY TAX						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,090,741	13		1.00
	0		0	1,090,741			
	D - TRAVEL/SCHEDULING						
1.00	ADMINISTRATIVE & GENERAL	5.00	79,739	7,645	0		1.00
	0		79,739	7,645			
	E - GUEST SERVICES						
1.00		0.00	0	0	0		1.00
	0		0	0			
	F - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	351,090	11		1.00
	0		0	351,090			
	G - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,263,918	12		1.00
2.00		0.00	0	0	0		2.00
	0		0	1,263,918			
	H - TRANSPORTATION						
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	84,231	100,754	0		1.00
	0		84,231	100,754			
500.00	Grand Total: Decreases		6,100,609	6,333,986			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 11/20/2015 12:12 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	869,428	257,177	0	257,177	0	2.00
3.00	Buildings and Fixtures	43,145,108	62,918,714	0	62,918,714	-6,777,707	3.00
4.00	Building Improvements	56,210,736	7,786,904	0	7,786,904	-199,412	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	78,000,960	14,844,203	0	14,844,203	-13,884,910	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	178,226,232	85,806,998	0	85,806,998	-20,862,029	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	178,226,232	85,806,998	0	85,806,998	-20,862,029	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	1,126,605	0	2.00
3.00	Buildings and Fixtures	112,841,529	0	3.00
4.00	Building Improvements	64,197,052	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	106,730,073	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	284,895,259	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	284,895,259	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 11/20/2015 12:12 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	14,581,743	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,977,042	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	26,558,785	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	14,581,743	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,977,042	2.00
3.00	Total (sum of lines 1-2)	0	26,558,785	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 11/20/2015 12:12 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	15,590,115	-5,680,613	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	13,655,458	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	29,245,573	-5,680,613	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-615,225	533,658	-1,090,741	0	8,737,194	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	13,655,458	2.00
3.00	Total (sum of lines 1-2)	-615,225	533,658	-1,090,741	0	22,392,652	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/20/2015 12:12 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-844,379	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-864,508			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	-273,449,136			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,363,661	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	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-239,858	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,404,883	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00			0		0.00	0	33.00
33.01	OTHER REVENUE	B	-834,712	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/20/2015 12:12 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	OTHER REVENUE	B	21	PHARMACY	15.00	0	33.02
33.03	OTHER REVENUE	B	1,043	SOCIAL SERVICE	17.00	0	33.03
33.04	OTHER REVENUE	B	-3,977	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05	OTHER REVENUE	B	648	OTHER GENERAL SERVICE (SPECIFY)	18.00	0	33.05
34.00	NON-ALLOWABLE EXPENSE	A	-88,421	SOCIAL SERVICE	17.00	0	34.00
34.01			0		0.00	0	34.01
34.02	NON-ALLOWABLE EXPENSE	A	-68	ADULTS & PEDIATRICS	30.00	0	34.02
34.03			0		0.00	0	34.03
34.04			0		0.00	0	34.04
34.05	NON-ALLOWABLE EXPENSE	A	-41	RADIOLOGY-DIAGNOSTIC	54.00	0	34.05
34.06			0		0.00	0	34.06
34.07			0		0.00	0	34.07
34.08	NON-ALLOWABLE EXPENSE	A	-143,436	OTHER GENERAL SERVICE (SPECIFY)	18.00	0	34.08
34.09	NON-ALLOWABLE EXPENSE	A	-462	DIETARY	10.00	0	34.09
34.10			0		0.00	0	34.10
34.11	NON-ALLOWABLE EXPENSE	A	-6,197,808	ADMINISTRATIVE & GENERAL	5.00	0	34.11
34.12	NON-ALLOWABLE EXPENSE	A	-93	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.12
34.13			0		0.00	0	34.13
34.14	NON-ALLOWABLE EXPENSE	A	-45,891	HOUSEKEEPING	9.00	0	34.14
34.15	NON-ALLOWABLE EXPENSE	A	-14,684	RADIOLOGY-THERAPEUTIC	55.00	0	34.15
34.16	NON-ALLOWABLE EXPENSE	A	-173	RESPIRATORY THERAPY	65.00	0	34.16
34.17			0		0.00	0	34.17
34.18	NON-ALLOWABLE EXPENSE	A	-71	CLINIC	90.00	0	34.18
34.19	NON-ALLOWABLE EXPENSE	A	-57	HOSPITAL NUTRITION	76.01	0	34.19
34.20	NON-ALLOWABLE EXPENSE	A	-20	NURSING ADMINISTRATION	13.00	0	34.20
34.21	NON-ALLOWABLE EXPENSE	A	-12	CENTRAL SERVICES & SUPPLY	14.00	0	34.21
34.22	NON-ALLOWABLE EXPENSE	A	-27	SURGICAL INTENSIVE CARE UNIT	34.00	0	34.22
34.23	NON-ALLOWABLE EXPENSE	A	-1,670	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	34.23
34.24	NON-ALLOWABLE EXPENSE	A	-92	PHYSICAL THERAPY	66.00	0	34.24
35.00	CAFETERIA	A	-2,692,453	CAFETERIA	11.00	0	35.00
36.00			0		0.00	0	36.00
37.00			0		0.00	0	37.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-288,188,881				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: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 11/20/2015 12:12 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00		MANAGEMENT FEES	0	0	1.00
2.00	0.00		RISING TIDE IP REIMBURSEMENT	0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	TRAVEL - AIR CHARTER	110,541	3,174,000	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	GUARANTEE FEES	0	101,412	4.00
4.01	113.00	INTEREST EXPENSE	INTEREST EXPENSE - OTHER	0	95,625	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES	6,045,471	6,045,471	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES -	0	857,150	4.03
4.04	113.00	INTEREST EXPENSE	INTEREST EXPENSE - GCF	0	440,460	4.04
4.05	113.00	INTEREST EXPENSE	INTEREST EXPENSE - CAPITAL L	351,090	0	4.05
4.06	1.00	CAP REL COSTS-BLDG & FIXT	RENTAL - BLDG	200,175	5,880,788	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES - NEW	0	31,681,504	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY EXPENSE	0	282,035,602	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	INSURANCE - COMMERCIAL	394,988	454,410	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	INSURANCE - STELLAR	1,534,269	4,743,797	4.10
4.11	1.00	CAP REL COSTS-BLDG & FIXT	INSURANCE - STELLAR	411,722	533,658	4.11
4.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	INSURANCE - STELLAR	482,135	730,260	4.12
4.13	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	1,248,230	0	4.13
4.14	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	3,940,449	0	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	49,165,921	0	4.15
4.16	5.00	ADMINISTRATIVE & GENERAL	BROKERAGE FEES	0	559,990	4.16
5.00	0		0	63,884,991	337,334,127	5.00

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

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

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

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

6.00	A	MIDWESTERN REG	100.00	NIMP	100.00	6.00
7.00	A	MIDWESTERN REG	100.00	CTCA	100.00	7.00
8.00	A	MIDWESTERN REG	100.00	ICIC	100.00	8.00
9.00	A	MIDWESTERN REG	100.00	INTERNATIONAL A	100.00	9.00
10.00	A	MIDWESTERN REG	100.00	SCL	100.00	10.00
10.01	A	MIDWESTERN REG	100.00	EXPEDITION PROP	100.00	10.01
10.02	A	MIDWESTERN REG	100.00	BUCKLEY RD PR	100.00	10.02
10.03	A	MIDWESTERN REG	100.00	LAND TRUST	100.00	10.03
10.04	A	MIDWESTERN REG	100.00	GCF	100.00	10.04
10.05	A	MIDWESTERN REG	100.00	STELLAR INS	100.00	10.05
10.06	A	MIDWESTERN REG	100.00	ICMC	100.00	10.06
10.07			0.00		0.00	10.07
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: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 11/20/2015 12:12 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	0	0		2.00
3.00	-3,063,459	0		3.00
4.00	-101,412	0		4.00
4.01	-95,625	0		4.01
4.02	0	9		4.02
4.03	-857,150	9		4.03
4.04	-440,460	0		4.04
4.05	351,090	0		4.05
4.06	-5,680,613	10		4.06
4.07	-31,681,504	0		4.07
4.08	-282,035,602	0		4.08
4.09	-59,422	0		4.09
4.10	-3,209,528	0		4.10
4.11	-121,936	11		4.11
4.12	-248,125	0		4.12
4.13	1,248,230	9		4.13
4.14	3,940,449	9		4.14
4.15	49,165,921	0		4.15
4.16	-559,990	0		4.16
5.00	-273,449,136			5.00

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

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

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

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

6.00	PROPERTY		6.00
7.00	MANAGEMENT		7.00
8.00	CONSULTING		8.00
9.00	CORPORATE JET		9.00
10.00	SECURITIES FINA		10.00
10.01	RENTS BLDG SHAR		10.01
10.02	PROPERTY COMP		10.02
10.03	PROPERTY COMP		10.03
10.04	FINANCIAL		10.04
10.05	INSURANCE		10.05
10.06	CAPITAL MANAGEM		10.06
10.07			10.07
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: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 11/20/2015 12:12 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	91.00	EMERGENCY	1,054,748	864,508	190,240	177,200	3,160	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	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,054,748	864,508	190,240		3,160	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	91.00	EMERGENCY	269,208	13,460	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	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			269,208	13,460	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	91.00	EMERGENCY	0	269,208	0	864,508		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	269,208	0	864,508		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/20/2015 12:12 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	8,737,194	8,737,194				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	13,655,458		13,655,458			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	21,510,727	206,593	5,971	21,723,291		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	67,155,998	318,943	4,593,010	2,462,306	74,530,257	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	7,935,099	2,086,768	443,818	459,604	10,925,289	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	176,630	0	0	0	176,630	8.00
9.00	00900	HOUSEKEEPING	2,416,954	133,384	12,104	399,858	2,962,300	9.00
10.00	01000	DIETARY	905,673	58,497	33,860	85,434	1,083,464	10.00
11.00	01100	CAFETERIA	1,297,500	345,635	0	504,758	2,147,893	11.00
13.00	01300	NURSING ADMINISTRATION	1,771,280	26,224	1,301	373,338	2,172,143	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,088,996	100,838	825,242	145,606	2,160,682	14.00
15.00	01500	PHARMACY	3,702,845	137,208	403,264	857,553	5,100,870	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,462,248	153,013	0	803,604	4,418,865	16.00
17.00	01700	SOCIAL SERVICE	1,133,183	50,575	0	227,527	1,411,285	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	9,266,937	188,486	0	2,110,364	11,565,787	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,231,616	1,020,516	64,943	2,093,976	12,411,051	30.00
31.00	03100	INTENSIVE CARE UNIT	2,339,916	133,735	186,103	544,544	3,204,298	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,956,214	0	218,136	714,884	3,889,234	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,793,507	661,495	1,797,210	1,175,403	10,427,615	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,157,521	446,122	1,406,387	943,084	7,953,114	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,831,838	504,619	1,092,038	632,847	8,061,342	55.00
56.00	05600	RADIOISOTOPE	680,786	15,610	160,670	121,760	978,826	56.00
57.00	05700	CT SCAN	812,595	25,834	405,929	158,007	1,402,365	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	917,468	57,990	987,230	129,287	2,091,975	58.00
60.00	06000	LABORATORY	9,879,465	282,846	393,180	857,636	11,413,127	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,431,832	11,395	52,604	0	1,495,831	63.00
64.00	06400	INTRAVENOUS THERAPY	2,562,499	246,553	905	610,515	3,420,472	64.00
65.00	06500	RESPIRATORY THERAPY	1,233,039	39,843	35,857	249,999	1,558,738	65.00
66.00	06600	PHYSICAL THERAPY	1,722,641	98,301	8,319	390,656	2,219,917	66.00
69.00	06900	ELECTROCARDIOLOGY	519,914	9,990	84,305	113,925	728,134	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,875,576	0	0	0	16,875,576	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,767,177	0	0	0	87,767,177	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	1,169,029	28,761	8,807	267,878	1,474,475	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,404,204	1,143,949	92,555	1,696,863	10,337,571	90.00
91.00	09100	EMERGENCY	1,514,963	89,755	40,437	318,368	1,963,523	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	311,018,522	8,623,478	13,354,185	19,449,584	308,329,826	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	79,508	16,429	0	0	95,937	190.00
191.00	19100	RESEARCH	703,977	0	952	155,794	860,723	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	47,325,582	97,287	300,321	2,117,913	49,841,103	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	359,127,589	8,737,194	13,655,458	21,723,291	359,127,589	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/20/2015 12:12 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	74,530,257					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	2,861,115	0	13,786,404			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,256	0	0	222,886		8.00
9.00	00900	HOUSEKEEPING	775,767	0	300,231	0	4,038,298	9.00
10.00	01000	DIETARY	283,738	0	131,670	0	39,427	10.00
11.00	01100	CAFETERIA	562,490	0	777,984	0	232,960	11.00
13.00	01300	NURSING ADMINISTRATION	568,841	0	59,027	0	17,675	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	565,839	0	226,974	0	67,965	14.00
15.00	01500	PHARMACY	1,335,816	0	308,840	0	92,479	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,157,212	0	344,414	0	103,131	16.00
17.00	01700	SOCIAL SERVICE	369,587	0	113,838	0	34,088	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	3,028,848	0	424,259	1,189	127,040	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,250,206	0	2,297,061	63,798	687,832	30.00
31.00	03100	INTENSIVE CARE UNIT	839,142	0	301,022	8,987	90,138	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,018,513	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,730,784	0	1,488,948	33,205	445,850	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,082,761	0	1,004,168	46,566	300,688	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,111,104	0	1,135,838	24,059	340,115	55.00
56.00	05600	RADIOISOTOPE	256,335	0	35,135	0	10,521	56.00
57.00	05700	CT SCAN	367,251	0	58,149	0	17,412	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	547,846	0	130,528	0	39,085	58.00
60.00	06000	LABORATORY	2,988,870	0	636,652	0	190,639	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	391,728	0	25,649	0	7,680	63.00
64.00	06400	INTRAVENOUS THERAPY	895,753	0	554,963	22,137	166,178	64.00
65.00	06500	RESPIRATORY THERAPY	408,202	0	89,683	0	26,855	65.00
66.00	06600	PHYSICAL THERAPY	581,352	0	221,265	7,355	66,256	66.00
69.00	06900	ELECTROCARDIOLOGY	190,684	0	22,487	2,064	6,733	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,419,376	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,984,377	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	386,136	0	64,737	0	19,385	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,707,203	0	2,574,893	10,484	771,026	90.00
91.00	09100	EMERGENCY	514,207	0	202,028	3,042	60,495	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	61,227,339	0	13,530,443	222,886	3,961,653	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,124	0	36,980	0	11,073	190.00
191.00	19100	RESEARCH	225,406	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	13,052,388	0	218,981	0	65,572	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)	74,530,257	0	13,786,404	222,886	4,038,298	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/20/2015 12:12 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,538,299					10.00
11.00	01100	CAFETERIA	0	3,721,327				11.00
13.00	01300	NURSING ADMINISTRATION	0	61,976	2,879,662			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	45,393	0	3,066,853		14.00
15.00	01500	PHARMACY	0	152,281	0	0	6,990,286	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	196,638	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	58,104	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	403,506	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,029,238	411,886	854,594	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	93,513	91,376	494,822	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	141,155	222,956	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	238,531	877,543	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	190,993	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	126,427	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	16,562	0	0	0	56.00
57.00	05700	CT SCAN	0	28,278	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	20,320	0	0	0	58.00
60.00	06000	LABORATORY	0	197,850	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	405,085	116,498	48,883	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	47,000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	79,500	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	19,561	284,253	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,066,853	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	6,990,286	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	65,364	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	347,416	47,728	0	0	90.00
91.00	09100	EMERGENCY	10,463	60,605	48,883	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,538,299	3,117,220	2,879,662	3,066,853	6,990,286	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	26,524	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	577,583	0	0	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)	1,538,299	3,721,327	2,879,662	3,066,853	6,990,286	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/20/2015 12:12 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	18.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,220,260					16.00
17.00	01700	SOCIAL SERVICE	0	1,986,902				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	15,550,629			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	116,669	37,262	291,637	21,451,234	0	30.00
31.00	03100	INTENSIVE CARE UNIT	23,826	7,609	59,557	5,214,290	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	29,514	9,426	73,776	5,384,574	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	460,025	146,923	1,149,925	17,999,349	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	272,644	87,077	681,529	12,619,540	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	383,898	122,610	959,632	13,265,025	0	55.00
56.00	05600	RADIOISOTOPE	30,658	9,792	76,636	1,414,465	0	56.00
57.00	05700	CT SCAN	453,703	144,904	1,134,123	3,606,185	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	111,941	35,752	279,819	3,257,266	0	58.00
60.00	06000	LABORATORY	451,853	144,313	1,129,498	17,152,802	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	36,063	11,518	90,148	2,058,617	0	63.00
64.00	06400	INTRAVENOUS THERAPY	175,042	55,905	437,553	6,298,469	0	64.00
65.00	06500	RESPIRATORY THERAPY	19,702	6,293	49,250	2,205,723	0	65.00
66.00	06600	PHYSICAL THERAPY	24,195	7,728	60,481	3,268,049	0	66.00
69.00	06900	ELECTROCARDIOLOGY	42,582	13,600	106,443	1,416,541	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	199,832	63,823	499,522	25,124,982	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,330,087	1,063,835	8,326,054	130,461,816	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	4,560	1,456	11,398	2,027,511	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	48,310	15,429	120,760	16,980,820	0	90.00
91.00	09100	EMERGENCY	5,156	1,647	12,888	2,882,937	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,220,260	1,986,902	15,550,629	294,090,195	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	169,114	0	190.00
191.00	19100	RESEARCH	0	0	0	1,112,653	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	63,755,627	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,220,260	1,986,902	15,550,629	359,127,589	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/20/2015 12:12 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	21,451,234		30.00
31.00	03100	INTENSIVE CARE UNIT	5,214,290		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,384,574		34.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	17,999,349		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,619,540		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	13,265,025		55.00
56.00	05600	RADIOISOTOPE	1,414,465		56.00
57.00	05700	CT SCAN	3,606,185		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,257,266		58.00
60.00	06000	LABORATORY	17,152,802		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,058,617		63.00
64.00	06400	INTRAVENOUS THERAPY	6,298,469		64.00
65.00	06500	RESPIRATORY THERAPY	2,205,723		65.00
66.00	06600	PHYSICAL THERAPY	3,268,049		66.00
69.00	06900	ELECTROCARDIOLOGY	1,416,541		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,124,982		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	130,461,816		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		76.00
76.01	03951	HOSPITAL NUTRITION	2,027,511		76.01
76.02	03952	PAIN MANAGEMENT	0		76.02
76.03	03954	INFUSION CENTER	0		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	16,980,820		90.00
91.00	09100	EMERGENCY	2,882,937		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	294,090,195		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	169,114		190.00
191.00	19100	RESEARCH	1,112,653		191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	63,755,627		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)	359,127,589		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/20/2015 12:12 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	206,593	5,971	212,564	212,564	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	318,943	4,593,010	4,911,953	24,119	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	2,086,768	443,818	2,530,586	4,497	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	133,384	12,104	145,488	3,912	9.00
10.00	01000	DIETARY	0	58,497	33,860	92,357	836	10.00
11.00	01100	CAFETERIA	0	345,635	0	345,635	4,938	11.00
13.00	01300	NURSING ADMINISTRATION	0	26,224	1,301	27,525	3,653	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	100,838	825,242	926,080	1,425	14.00
15.00	01500	PHARMACY	0	137,208	403,264	540,472	8,390	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	153,013	0	153,013	7,862	16.00
17.00	01700	SOCIAL SERVICE	0	50,575	0	50,575	2,226	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	188,486	0	188,486	20,647	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,020,516	64,943	1,085,459	20,487	30.00
31.00	03100	INTENSIVE CARE UNIT	0	133,735	186,103	319,838	5,328	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	218,136	218,136	6,994	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	661,495	1,797,210	2,458,705	11,500	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	446,122	1,406,387	1,852,509	9,227	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	504,619	1,092,038	1,596,657	6,192	55.00
56.00	05600	RADIOISOTOPE	0	15,610	160,670	176,280	1,191	56.00
57.00	05700	CT SCAN	0	25,834	405,929	431,763	1,546	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	57,990	987,230	1,045,220	1,265	58.00
60.00	06000	LABORATORY	0	282,846	393,180	676,026	8,391	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	11,395	52,604	63,999	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	246,553	905	247,458	5,973	64.00
65.00	06500	RESPIRATORY THERAPY	0	39,843	35,857	75,700	2,446	65.00
66.00	06600	PHYSICAL THERAPY	0	98,301	8,319	106,620	3,822	66.00
69.00	06900	ELECTROCARDIOLOGY	0	9,990	84,305	94,295	1,115	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	28,761	8,807	37,568	2,621	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,143,949	92,555	1,236,504	16,601	90.00
91.00	09100	EMERGENCY	0	89,755	40,437	130,192	3,115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	8,623,478	13,354,185	21,977,663	190,319	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,429	0	16,429	0	190.00
191.00	19100	RESEARCH	0	0	952	952	1,524	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	97,287	300,321	397,608	20,721	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	8,737,194	13,655,458	22,392,652	212,564	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/20/2015 12:12 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,936,072					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	189,488	0	2,724,571			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,063	0	0	3,063		8.00
9.00	00900	HOUSEKEEPING	51,378	0	59,334	0	260,112	9.00
10.00	01000	DIETARY	18,792	0	26,022	0	2,540	10.00
11.00	01100	CAFETERIA	37,253	0	153,751	0	15,005	11.00
13.00	01300	NURSING ADMINISTRATION	37,674	0	11,665	0	1,138	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37,475	0	44,856	0	4,378	14.00
15.00	01500	PHARMACY	88,469	0	61,035	0	5,957	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	76,641	0	68,066	0	6,643	16.00
17.00	01700	SOCIAL SERVICE	24,477	0	22,498	0	2,196	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	200,597	0	83,845	16	8,183	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	215,257	0	453,962	877	44,304	30.00
31.00	03100	INTENSIVE CARE UNIT	55,575	0	59,490	124	5,806	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	67,455	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	180,857	0	294,257	456	28,718	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	137,939	0	198,451	640	19,368	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	139,816	0	224,473	331	21,907	55.00
56.00	05600	RADIOISOTOPE	16,977	0	6,944	0	678	56.00
57.00	05700	CT SCAN	24,323	0	11,492	0	1,122	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	36,283	0	25,796	0	2,518	58.00
60.00	06000	LABORATORY	197,949	0	125,820	0	12,279	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	25,944	0	5,069	0	495	63.00
64.00	06400	INTRAVENOUS THERAPY	59,325	0	109,676	304	10,704	64.00
65.00	06500	RESPIRATORY THERAPY	27,035	0	17,724	0	1,730	65.00
66.00	06600	PHYSICAL THERAPY	38,502	0	43,728	101	4,268	66.00
69.00	06900	ELECTROCARDIOLOGY	12,629	0	4,444	28	434	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	292,690	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,522,250	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	25,573	0	12,794	0	1,249	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	179,295	0	508,868	144	49,658	90.00
91.00	09100	EMERGENCY	34,055	0	39,926	42	3,897	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,055,036	0	2,673,986	3,063	255,175	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,664	0	7,308	0	713	190.00
191.00	19100	RESEARCH	14,928	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	864,444	0	43,277	0	4,224	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)	4,936,072	0	2,724,571	3,063	260,112	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/20/2015 12:12 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	140,547					10.00
11.00	01100	CAFETERIA	0	556,582				11.00
13.00	01300	NURSING ADMINISTRATION	0	9,270	90,925			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,789	0	1,021,003		14.00
15.00	01500	PHARMACY	0	22,776	0	0	727,099	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,410	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	8,690	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	60,351	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	94,036	61,604	26,984	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	8,544	13,667	15,624	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	21,112	7,040	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	35,676	27,709	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,566	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	18,909	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	2,477	0	0	0	56.00
57.00	05700	CT SCAN	0	4,229	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,039	0	0	0	58.00
60.00	06000	LABORATORY	0	29,591	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	37,011	17,424	1,543	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,030	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	11,890	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,926	8,975	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,021,003	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	727,099	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	9,776	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	51,961	1,507	0	0	90.00
91.00	09100	EMERGENCY	956	9,064	1,543	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	140,547	466,227	90,925	1,021,003	727,099	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	3,967	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	86,388	0	0	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)	140,547	556,582	90,925	1,021,003	727,099	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/20/2015 12:12 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	18.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	341,635					16.00
17.00	01700	SOCIAL SERVICE	0	110,662				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	562,125			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,411	2,083	10,554	2,022,018	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,309	425	2,155	487,885	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,622	527	2,670	325,556	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,278	8,213	41,613	3,112,982	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,982	4,868	24,663	2,291,213	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	21,095	6,854	34,727	2,070,961	0	55.00
56.00	05600	RADIOISOTOPE	1,685	547	2,773	209,552	0	56.00
57.00	05700	CT SCAN	24,931	8,100	41,041	548,547	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,151	1,999	10,126	1,132,397	0	58.00
60.00	06000	LABORATORY	24,829	8,067	40,874	1,123,826	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,982	644	3,262	101,395	0	63.00
64.00	06400	INTRAVENOUS THERAPY	9,618	3,125	15,834	517,995	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,083	352	1,782	134,882	0	65.00
66.00	06600	PHYSICAL THERAPY	1,330	432	2,189	212,882	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,340	760	3,852	131,798	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,981	3,568	18,076	1,346,318	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	182,819	59,062	300,686	2,791,916	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	251	81	412	90,325	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,655	863	4,370	2,052,426	0	90.00
91.00	09100	EMERGENCY	283	92	466	223,631	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	341,635	110,662	562,125	20,928,505	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	26,114	0	190.00
191.00	19100	RESEARCH	0	0	0	21,371	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	1,416,662	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	341,635	110,662	562,125	22,392,652	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/20/2015 12:12 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,022,018		30.00
31.00	03100	INTENSIVE CARE UNIT	487,885		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	325,556		34.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	3,112,982		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,291,213		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,070,961		55.00
56.00	05600	RADIOISOTOPE	209,552		56.00
57.00	05700	CT SCAN	548,547		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,132,397		58.00
60.00	06000	LABORATORY	1,123,826		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	101,395		63.00
64.00	06400	INTRAVENOUS THERAPY	517,995		64.00
65.00	06500	RESPIRATORY THERAPY	134,882		65.00
66.00	06600	PHYSICAL THERAPY	212,882		66.00
69.00	06900	ELECTROCARDIOLOGY	131,798		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,346,318		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,791,916		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		76.00
76.01	03951	HOSPITAL NUTRITION	90,325		76.01
76.02	03952	PAIN MANAGEMENT	0		76.02
76.03	03954	INFUSION CENTER	0		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	2,052,426		90.00
91.00	09100	EMERGENCY	223,631		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,928,505		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	26,114		190.00
191.00	19100	RESEARCH	21,371		191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	1,416,662		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)	22,392,652		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/20/2015 12:12 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	223,893					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		13,670,068				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,294	5,977	78,920,322			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,173	4,597,926	8,945,515	-74,530,257	284,597,332	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	53,474	444,293	1,669,732	0	10,925,289	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	176,630	8.00
9.00	00900	HOUSEKEEPING	3,418	12,117	1,452,678	0	2,962,300	9.00
10.00	01000	DIETARY	1,499	33,896	310,379	0	1,083,464	10.00
11.00	01100	CAFETERIA	8,857	0	1,833,776	0	2,147,893	11.00
13.00	01300	NURSING ADMINISTRATION	672	1,302	1,356,331	0	2,172,143	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,584	826,125	528,984	0	2,160,682	14.00
15.00	01500	PHARMACY	3,516	403,696	3,115,475	0	5,100,870	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,921	0	2,919,480	0	4,418,865	16.00
17.00	01700	SOCIAL SERVICE	1,296	0	826,603	0	1,411,285	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	4,830	0	7,666,913	0	11,565,787	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,151	65,012	7,607,378	0	12,411,051	30.00
31.00	03100	INTENSIVE CARE UNIT	3,427	186,302	1,978,319	0	3,204,298	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	218,369	2,597,160	0	3,889,234	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,951	1,799,133	4,270,219	0	10,427,615	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,432	1,407,892	3,426,208	0	7,953,114	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,931	1,093,207	2,299,120	0	8,061,342	55.00
56.00	05600	RADIOISOTOPE	400	160,842	442,352	0	978,826	56.00
57.00	05700	CT SCAN	662	406,363	574,036	0	1,402,365	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,486	988,286	469,696	0	2,091,975	58.00
60.00	06000	LABORATORY	7,248	393,601	3,115,775	0	11,413,127	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	292	52,660	0	0	1,495,831	63.00
64.00	06400	INTRAVENOUS THERAPY	6,318	906	2,217,989	0	3,420,472	64.00
65.00	06500	RESPIRATORY THERAPY	1,021	35,895	908,241	0	1,558,738	65.00
66.00	06600	PHYSICAL THERAPY	2,519	8,328	1,419,247	0	2,219,917	66.00
69.00	06900	ELECTROCARDIOLOGY	256	84,395	413,889	0	728,134	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	16,875,576	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	87,767,177	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	737	8,816	973,196	0	1,474,475	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	29,314	92,654	6,164,672	0	10,337,571	90.00
91.00	09100	EMERGENCY	2,300	40,480	1,156,626	0	1,963,523	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	220,979	13,368,473	70,659,989	-74,530,257	233,799,569	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	421	0	0	0	95,937	190.00
191.00	19100	RESEARCH	0	953	565,995	0	860,723	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	2,493	300,642	7,694,338	0	49,841,103	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)	8,737,194	13,655,458	21,723,291		74,530,257	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.023971	0.998931	0.275256		0.261880	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			212,564		4,936,072	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002693		0.017344	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/20/2015 12:12 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	210,426					6.00
7.00	00700	OPERATION OF PLANT	53,474	156,952				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	596,173			8.00
9.00	00900	HOUSEKEEPING	3,418	3,418	0	153,534		9.00
10.00	01000	DIETARY	1,499	1,499	0	1,499	51,900	10.00
11.00	01100	CAFETERIA	8,857	8,857	0	8,857	0	11.00
13.00	01300	NURSING ADMINISTRATION	672	672	0	672	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,584	2,584	0	2,584	0	14.00
15.00	01500	PHARMACY	3,516	3,516	0	3,516	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,921	3,921	0	3,921	0	16.00
17.00	01700	SOCIAL SERVICE	1,296	1,296	0	1,296	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	4,830	4,830	3,180	4,830	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,151	26,151	170,645	26,151	34,725	30.00
31.00	03100	INTENSIVE CARE UNIT	3,427	3,427	24,039	3,427	3,155	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,951	16,951	88,816	16,951	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,432	11,432	124,554	11,432	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,931	12,931	64,353	12,931	0	55.00
56.00	05600	RADIOISOTOPE	400	400	0	400	0	56.00
57.00	05700	CT SCAN	662	662	0	662	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,486	1,486	0	1,486	0	58.00
60.00	06000	LABORATORY	7,248	7,248	0	7,248	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	292	292	0	292	0	63.00
64.00	06400	INTRAVENOUS THERAPY	6,318	6,318	59,213	6,318	13,667	64.00
65.00	06500	RESPIRATORY THERAPY	1,021	1,021	0	1,021	0	65.00
66.00	06600	PHYSICAL THERAPY	2,519	2,519	19,673	2,519	0	66.00
69.00	06900	ELECTROCARDIOLOGY	256	256	5,520	256	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	737	737	0	737	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	29,314	29,314	28,043	29,314	0	90.00
91.00	09100	EMERGENCY	2,300	2,300	8,137	2,300	353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	207,512	154,038	596,173	150,620	51,900	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	421	421	0	421	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	2,493	2,493	0	2,493	0	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)	0	13,786,404	222,886	4,038,298	1,538,299	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	87.838345	0.373861	26.302304	29.639672	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	2,724,571	3,063	260,112	140,547	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	17.359263	0.005138	1.694165	2.708035	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/20/2015 12:12 pm

		Cost Center Description	CAFETERIA (ASSIGNED TIME)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,027,634					11.00
13.00	01300	NURSING ADMINISTRATION	33,769	643,053				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	24,733	0	1,000			14.00
15.00	01500	PHARMACY	82,973	0	0	1,000		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	107,142	0	0	0	1,234,031,983	16.00
17.00	01700	SOCIAL SERVICE	31,659	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	219,858	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	224,424	190,838	0	0	23,143,922	30.00
31.00	03100	INTENSIVE CARE UNIT	49,788	110,498	0	0	4,726,387	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	76,911	49,788	0	0	5,854,765	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	129,968	195,963	0	0	91,256,650	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	104,066	0	0	0	54,085,289	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	68,886	0	0	0	76,155,204	55.00
56.00	05600	RADIOISOTOPE	9,024	0	0	0	6,081,705	56.00
57.00	05700	CT SCAN	15,408	0	0	0	90,002,630	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,072	0	0	0	22,206,088	58.00
60.00	06000	LABORATORY	107,802	0	0	0	89,635,569	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	7,154,013	63.00
64.00	06400	INTRAVENOUS THERAPY	63,476	10,916	0	0	34,723,708	64.00
65.00	06500	RESPIRATORY THERAPY	25,609	0	0	0	3,908,413	65.00
66.00	06600	PHYSICAL THERAPY	43,317	0	0	0	4,799,696	66.00
69.00	06900	ELECTROCARDIOLOGY	10,658	63,476	0	0	8,447,148	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,000	0	39,641,429	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,000	660,698,665	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	35,615	0	0	0	904,536	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	189,296	10,658	0	0	9,583,390	90.00
91.00	09100	EMERGENCY	33,022	10,916	0	0	1,022,776	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,698,476	643,053	1,000	1,000	1,234,031,983	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	14,452	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	314,706	0	0	0	0	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)	3,721,327	2,879,662	3,066,853	6,990,286	6,220,260	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.835305	4.478110	3,066.853000	6,990.286000	0.005041	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	556,582	90,925	1,021,003	727,099	341,635	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.274498	0.141396	1,021.003000	727.099000	0.000277	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/20/2015 12:12 pm

		Cost Center Description	SOCIAL SERVICE (GROSS CHARGES)	OTHER GENERAL SERVICE (SPECIFY) (GROSS CHARGES)		
			17.00	18.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	1,234,031,983			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	1,234,031,983		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	23,143,922	23,143,922		30.00
31.00	03100	INTENSIVE CARE UNIT	4,726,387	4,726,387		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,854,765	5,854,765		34.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	91,256,650	91,256,650		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,085,289	54,085,289		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	76,155,204	76,155,204		55.00
56.00	05600	RADIOISOTOPE	6,081,705	6,081,705		56.00
57.00	05700	CT SCAN	90,002,630	90,002,630		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	22,206,088	22,206,088		58.00
60.00	06000	LABORATORY	89,635,569	89,635,569		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,154,013	7,154,013		63.00
64.00	06400	INTRAVENOUS THERAPY	34,723,708	34,723,708		64.00
65.00	06500	RESPIRATORY THERAPY	3,908,413	3,908,413		65.00
66.00	06600	PHYSICAL THERAPY	4,799,696	4,799,696		66.00
69.00	06900	ELECTROCARDIOLOGY	8,447,148	8,447,148		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,641,429	39,641,429		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	660,698,665	660,698,665		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	904,536	904,536		76.01
76.02	03952	PAIN MANAGEMENT	0	0		76.02
76.03	03954	INFUSION CENTER	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	9,583,390	9,583,390		90.00
91.00	09100	EMERGENCY	1,022,776	1,022,776		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,234,031,983	1,234,031,983		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		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)	1,986,902	15,550,629		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001610	0.012601		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	110,662	562,125		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000090	0.000456		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,451,234		21,451,234	0	21,451,234	30.00
31.00	03100	INTENSIVE CARE UNIT	5,214,290		5,214,290	0	5,214,290	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,384,574		5,384,574	0	5,384,574	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,999,349		17,999,349	0	17,999,349	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,619,540		12,619,540	0	12,619,540	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	13,265,025		13,265,025	0	13,265,025	55.00
56.00	05600	RADIOISOTOPE	1,414,465		1,414,465	0	1,414,465	56.00
57.00	05700	CT SCAN	3,606,185		3,606,185	0	3,606,185	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,257,266		3,257,266	0	3,257,266	58.00
60.00	06000	LABORATORY	17,152,802		17,152,802	0	17,152,802	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,058,617		2,058,617	0	2,058,617	63.00
64.00	06400	INTRAVENOUS THERAPY	6,298,469		6,298,469	0	6,298,469	64.00
65.00	06500	RESPIRATORY THERAPY	2,205,723	0	2,205,723	0	2,205,723	65.00
66.00	06600	PHYSICAL THERAPY	3,268,049	0	3,268,049	0	3,268,049	66.00
69.00	06900	ELECTROCARDIOLOGY	1,416,541		1,416,541	0	1,416,541	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,124,982		25,124,982	0	25,124,982	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	130,461,816		130,461,816	0	130,461,816	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	2,027,511		2,027,511	0	2,027,511	76.01
76.02	03952	PAIN MANAGEMENT	0		0	0	0	76.02
76.03	03954	INFUSION CENTER	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	16,980,820		16,980,820	0	16,980,820	90.00
91.00	09100	EMERGENCY	2,882,937		2,882,937	0	2,882,937	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,657,630		2,657,630		2,657,630	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	296,747,825	0	296,747,825	0	296,747,825	200.00
201.00		Less Observation Beds	2,657,630		2,657,630		2,657,630	201.00
202.00		Total (see instructions)	294,090,195	0	294,090,195	0	294,090,195	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,205,819		21,205,819			30.00
31.00	03100	INTENSIVE CARE UNIT	4,726,387		4,726,387			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,854,765		5,854,765			34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,093,586	41,163,064	91,256,650	0.197239	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,400,601	46,684,688	54,085,289	0.233327	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,142,501	73,012,703	76,155,204	0.174184	0.000000	55.00
56.00	05600	RADIOISOTOPE	238,981	5,842,724	6,081,705	0.232577	0.000000	56.00
57.00	05700	CT SCAN	5,691,965	84,310,665	90,002,630	0.040068	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,388,288	19,817,800	22,206,088	0.146683	0.000000	58.00
60.00	06000	LABORATORY	16,791,463	72,844,106	89,635,569	0.191362	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,008,733	3,145,280	7,154,013	0.287757	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	106,213	34,617,495	34,723,708	0.181388	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,520,987	2,387,426	3,908,413	0.564353	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,478,733	2,320,963	4,799,696	0.680887	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,531,956	6,915,192	8,447,148	0.167695	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,199,389	16,442,040	39,641,429	0.633806	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,319,943	588,378,722	660,698,665	0.197460	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	17,594	886,942	904,536	2.241493	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	855,699	8,727,691	9,583,390	1.771901	0.000000	90.00
91.00	09100	EMERGENCY	81,900	940,876	1,022,776	2.818737	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	668,544	1,269,559	1,938,103	1.371253	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	224,324,047	1,009,707,936	1,234,031,983			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	224,324,047	1,009,707,936	1,234,031,983			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.197239
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233327
55.00	05500	RADIOLOGY-THERAPEUTIC	0.174184
56.00	05600	RADIOISOTOPE	0.232577
57.00	05700	CT SCAN	0.040068
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.146683
60.00	06000	LABORATORY	0.191362
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.287757
64.00	06400	INTRAVENOUS THERAPY	0.181388
65.00	06500	RESPIRATORY THERAPY	0.564353
66.00	06600	PHYSICAL THERAPY	0.680887
69.00	06900	ELECTROCARDIOLOGY	0.167695
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.633806
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0.197460
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000
76.01	03951	HOSPITAL NUTRITION	2.241493
76.02	03952	PAIN MANAGEMENT	0.000000
76.03	03954	INFUSION CENTER	0.000000
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	1.771901
91.00	09100	EMERGENCY	2.818737
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.371253
		SPECIAL PURPOSE COST CENTERS	
113.00	11300	INTEREST EXPENSE	
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/20/2015 12:12 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,451,234		21,451,234	0	21,451,234	30.00
31.00	03100	INTENSIVE CARE UNIT	5,214,290		5,214,290	0	5,214,290	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,384,574		5,384,574	0	5,384,574	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,999,349		17,999,349	0	17,999,349	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,619,540		12,619,540	0	12,619,540	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	13,265,025		13,265,025	0	13,265,025	55.00
56.00	05600	RADIOISOTOPE	1,414,465		1,414,465	0	1,414,465	56.00
57.00	05700	CT SCAN	3,606,185		3,606,185	0	3,606,185	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,257,266		3,257,266	0	3,257,266	58.00
60.00	06000	LABORATORY	17,152,802		17,152,802	0	17,152,802	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,058,617		2,058,617	0	2,058,617	63.00
64.00	06400	INTRAVENOUS THERAPY	6,298,469		6,298,469	0	6,298,469	64.00
65.00	06500	RESPIRATORY THERAPY	2,205,723	0	2,205,723	0	2,205,723	65.00
66.00	06600	PHYSICAL THERAPY	3,268,049	0	3,268,049	0	3,268,049	66.00
69.00	06900	ELECTROCARDIOLOGY	1,416,541		1,416,541	0	1,416,541	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,124,982		25,124,982	0	25,124,982	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	130,461,816		130,461,816	0	130,461,816	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	2,027,511		2,027,511	0	2,027,511	76.01
76.02	03952	PAIN MANAGEMENT	0		0	0	0	76.02
76.03	03954	INFUSION CENTER	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	16,980,820		16,980,820	0	16,980,820	90.00
91.00	09100	EMERGENCY	2,882,937		2,882,937	0	2,882,937	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,657,630		2,657,630		2,657,630	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	296,747,825	0	296,747,825	0	296,747,825	200.00
201.00		Less Observation Beds	2,657,630		2,657,630		2,657,630	201.00
202.00		Total (see instructions)	294,090,195	0	294,090,195	0	294,090,195	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/20/2015 12:12 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,205,819		21,205,819			30.00
31.00	03100	INTENSIVE CARE UNIT	4,726,387		4,726,387			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,854,765		5,854,765			34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,093,586	41,163,064	91,256,650	0.197239	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,400,601	46,684,688	54,085,289	0.233327	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,142,501	73,012,703	76,155,204	0.174184	0.000000	55.00
56.00	05600	RADIOISOTOPE	238,981	5,842,724	6,081,705	0.232577	0.000000	56.00
57.00	05700	CT SCAN	5,691,965	84,310,665	90,002,630	0.040068	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,388,288	19,817,800	22,206,088	0.146683	0.000000	58.00
60.00	06000	LABORATORY	16,791,463	72,844,106	89,635,569	0.191362	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,008,733	3,145,280	7,154,013	0.287757	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	106,213	34,617,495	34,723,708	0.181388	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,520,987	2,387,426	3,908,413	0.564353	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,478,733	2,320,963	4,799,696	0.680887	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,531,956	6,915,192	8,447,148	0.167695	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,199,389	16,442,040	39,641,429	0.633806	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,319,943	588,378,722	660,698,665	0.197460	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	17,594	886,942	904,536	2.241493	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	855,699	8,727,691	9,583,390	1.771901	0.000000	90.00
91.00	09100	EMERGENCY	81,900	940,876	1,022,776	2.818737	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	668,544	1,269,559	1,938,103	1.371253	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	224,324,047	1,009,707,936	1,234,031,983			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	224,324,047	1,009,707,936	1,234,031,983			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/20/2015 12:12 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	76.02
76.03	03954	INFUSION CENTER	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
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
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part I Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,022,018	0	2,022,018	9,137	221.30	30.00
31.00	INTENSIVE CARE UNIT	487,885		487,885	1,505	324.18	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	325,556		325,556	2,191	148.59	34.00
200.00	Total (lines 30-199)	2,835,459		2,835,459	12,833		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	714	158,008				30.00
31.00	INTENSIVE CARE UNIT	75	24,314				31.00
34.00	SURGICAL INTENSIVE CARE UNIT	161	23,923				34.00
200.00	Total (lines 30-199)	950	206,245				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,112,982	91,256,650	0.034112	3,550,628	121,119	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,291,213	54,085,289	0.042363	737,697	31,251	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,070,961	76,155,204	0.027194	302,599	8,229	55.00
56.00	05600	RADIOISOTOPE	209,552	6,081,705	0.034456	16,129	556	56.00
57.00	05700	CT SCAN	548,547	90,002,630	0.006095	599,656	3,655	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,132,397	22,206,088	0.050995	275,158	14,032	58.00
60.00	06000	LABORATORY	1,123,826	89,635,569	0.012538	1,467,072	18,394	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	101,395	7,154,013	0.014173	325,316	4,611	63.00
64.00	06400	INTRAVENOUS THERAPY	517,995	34,723,708	0.014918	16,739	250	64.00
65.00	06500	RESPIRATORY THERAPY	134,882	3,908,413	0.034511	206,887	7,140	65.00
66.00	06600	PHYSICAL THERAPY	212,882	4,799,696	0.044353	230,794	10,236	66.00
69.00	06900	ELECTROCARDIOLOGY	131,798	8,447,148	0.015603	212,153	3,310	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,346,318	39,641,429	0.033962	1,760,607	59,794	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,791,916	660,698,665	0.004226	4,793,770	20,258	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	90,325	904,536	0.099858	2,094	209	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0.000000	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,052,426	9,583,390	0.214165	97,997	20,988	90.00
91.00	09100	EMERGENCY	223,631	1,022,776	0.218651	6,432	1,406	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	250,511	1,938,103	0.129256	48,510	6,270	92.00
200.00		Total (lines 50-199)	18,343,557	1,202,245,012		14,650,238	331,708	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part III Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,137	0.00	714	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,505	0.00	75	0		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,191	0.00	161	0		34.00
200.00		Total (lines 30-199)	12,833		950	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	0	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	91,256,650	0.000000	0.000000	3,550,628	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,085,289	0.000000	0.000000	737,697	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	76,155,204	0.000000	0.000000	302,599	55.00
56.00	05600	RADIOISOTOPE	0	6,081,705	0.000000	0.000000	16,129	56.00
57.00	05700	CT SCAN	0	90,002,630	0.000000	0.000000	599,656	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	22,206,088	0.000000	0.000000	275,158	58.00
60.00	06000	LABORATORY	0	89,635,569	0.000000	0.000000	1,467,072	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	7,154,013	0.000000	0.000000	325,316	63.00
64.00	06400	INTRAVENOUS THERAPY	0	34,723,708	0.000000	0.000000	16,739	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,908,413	0.000000	0.000000	206,887	65.00
66.00	06600	PHYSICAL THERAPY	0	4,799,696	0.000000	0.000000	230,794	66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,447,148	0.000000	0.000000	212,153	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39,641,429	0.000000	0.000000	1,760,607	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	660,698,665	0.000000	0.000000	4,793,770	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	904,536	0.000000	0.000000	2,094	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0.000000	0.000000	0	76.02
76.03	03954	INFUSION CENTER	0	0	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	9,583,390	0.000000	0.000000	97,997	90.00
91.00	09100	EMERGENCY	0	1,022,776	0.000000	0.000000	6,432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,938,103	0.000000	0.000000	48,510	92.00
200.00		Total (lines 50-199)	0	1,202,245,012			14,650,238	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	3,321,177	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,228,659	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,309,597	0		55.00
56.00	05600	RADIOISOTOPE	0	865,987	0		56.00
57.00	05700	CT SCAN	0	9,151,787	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,562,851	0		58.00
60.00	06000	LABORATORY	0	4,557,009	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	127,385	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,422,841	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	157,238	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	497,286	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,311,531	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	42,373,683	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	0	0	0		76.01
76.02	03952	PAIN MANAGEMENT	0	0	0		76.02
76.03	03954	INFUSION CENTER	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	754,276	0		90.00
91.00	09100	EMERGENCY	0	53,400	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	51,335	0		92.00
200.00		Total (lines 50-199)	0	76,746,042	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.197239	3,321,177	0	0	655,066	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233327	4,228,659	0	0	986,660	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.174184	5,309,597	0	0	924,847	55.00
56.00	05600	RADIOISOTOPE	0.232577	865,987	0	0	201,409	56.00
57.00	05700	CT SCAN	0.040068	9,151,787	0	0	366,694	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.146683	1,562,851	0	0	229,244	58.00
60.00	06000	LABORATORY	0.191362	4,557,009	28,999	0	872,038	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.287757	127,385	0	0	36,656	63.00
64.00	06400	INTRAVENOUS THERAPY	0.181388	2,422,841	0	0	439,474	64.00
65.00	06500	RESPIRATORY THERAPY	0.564353	157,238	0	0	88,738	65.00
66.00	06600	PHYSICAL THERAPY	0.680887	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.167695	497,286	0	0	83,392	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.633806	1,311,531	0	0	831,256	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.197460	42,373,683	464	172,201	8,367,107	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	2.241493	0	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.771901	754,276	0	280	1,336,502	90.00
91.00	09100	EMERGENCY	2.818737	53,400	0	0	150,521	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.371253	51,335	0	0	70,393	92.00
200.00		Subtotal (see instructions)		76,746,042	29,463	172,481	15,639,997	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		76,746,042	29,463	172,481	15,639,997	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
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
60.00	06000	LABORATORY	5,549	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	92	34,003		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	0	0		76.01
76.02	03952	PAIN MANAGEMENT	0	0		76.02
76.03	03954	INFUSION CENTER	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	496		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)	5,641	34,499		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,641	34,499		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,137	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,137	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)	8,005	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)	714	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	21,451,234	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)	21,451,234	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	21,451,234	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,347.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,676,279	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)	1,676,279	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,214,290	1,505	3,464.64	75	259,848	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	5,384,574	2,191	2,457.59	161	395,672	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,005,608	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,337,407	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)	206,245	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	331,708	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	537,953	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,799,454	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,132	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,347.73	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,657,630	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,022,018	21,451,234	0.094261	2,657,630	250,511	90.00
91.00	Nursing School cost	0	21,451,234	0.000000	2,657,630	0	91.00
92.00	Allied health cost	0	21,451,234	0.000000	2,657,630	0	92.00
93.00	All other Medical Education	0	21,451,234	0.000000	2,657,630	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,548,140		30.00
31.00	03100	INTENSIVE CARE UNIT		348,632		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		463,859		34.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.197239	3,550,628	700,322	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233327	737,697	172,125	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.174184	302,599	52,708	55.00
56.00	05600	RADIOISOTOPE	0.232577	16,129	3,751	56.00
57.00	05700	CT SCAN	0.040068	599,656	24,027	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.146683	275,158	40,361	58.00
60.00	06000	LABORATORY	0.191362	1,467,072	280,742	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.287757	325,316	93,612	63.00
64.00	06400	INTRAVENOUS THERAPY	0.181388	16,739	3,036	64.00
65.00	06500	RESPIRATORY THERAPY	0.564353	206,887	116,757	65.00
66.00	06600	PHYSICAL THERAPY	0.680887	230,794	157,145	66.00
69.00	06900	ELECTROCARDIOLOGY	0.167695	212,153	35,577	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.633806	1,760,607	1,115,883	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.197460	4,793,770	946,578	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	2.241493	2,094	4,694	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.771901	97,997	173,641	90.00
91.00	09100	EMERGENCY	2.818737	6,432	18,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.371253	48,510	66,519	92.00
200.00		Total (sum of lines 50-94 and 96-98)		14,650,238	4,005,608	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		14,650,238		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A | Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		898,506			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		883,856			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0			1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0			1.04
2.00	Outlier payments for discharges. (see instructions)		1,175,112			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)		69.90			4.00
	Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00			5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00			6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00			7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00			7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00			8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00			8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00			9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00			10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00			11.00
12.00	Current year allowable FTE (see instructions)		0.00			12.00
13.00	Total allowable FTE count for the prior year.		0.00			13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00			14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00			15.00
16.00	Adjustment for residents in initial years of the program		0.00			16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00			17.00
18.00	Adjusted rolling average FTE count		0.00			18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000			19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000			20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000			21.00
22.00	IME payment adjustment (see instructions)		0			22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0			22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00			23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00			24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00			25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000			26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000			27.00
28.00	IME add-on adjustment amount (see instructions)		0			28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0			28.01
29.00	Total IME payment (sum of lines 22 and 28)		0			29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A | Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0			29.01
	Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00			30.00
31.00	Percentage of Medicaid patient days (see instructions)		0.00			31.00
32.00	Sum of lines 30 and 31		0.00			32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00			33.00
34.00	Disproportionate share adjustment (see instructions)		0			34.00

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		9,046,380,143		7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000001620		0.000003015	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0		0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0		0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0			36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0			46.00
47.00	Subtotal (see instructions)		2,957,474			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)		2,957,474			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		236,931			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		3,194,405			59.00
60.00	Primary payer payments		0			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		3,194,405			61.00
62.00	Deductibles billed to program beneficiaries		143,300			62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Date/Time Prepared: 11/20/2015 12:12 pm

Title XVIII | Hospital | PPS

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
63.00	Coinsurance billed to program beneficiaries		0			63.00
64.00	Allowable bad debts (see instructions)		9,588			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		6,232			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		3,057,337			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)		8,486			70.93
70.94	HRR adjustment amount (see instructions)		0			70.94
70.95	Recovery of accelerated depreciation		0			70.95
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)		3,065,823			71.00
71.01	Sequestration adjustment (see instructions)		61,316			71.01
72.00	Interim payments		3,016,103			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)		-11,596			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0			75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0			90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00			94.00
95.00	Time value of money for operating expenses (see instructions)		0			95.00
96.00	Time value of money for capital related expenses (see instructions)		0			96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140100	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prepared: 11/20/2015 12:12 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1		On/After 10/1	
		1.00	1.01	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		0	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: 140100	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/20/2015 12:12 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	40,140	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	15,639,997	2.00
3.00	PPS payments	9,751,370	3.00
4.00	Outlier payment (see instructions)	94,923	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	40,140	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	201,944	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)	201,944	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	201,944	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	161,804	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)	40,140	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)	9,846,293	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,796,868	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)	8,089,565	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)	8,089,565	30.00
31.00	Primary payer payments	2,917	31.00
32.00	Subtotal (line 30 minus line 31)	8,086,648	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	139,113	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	90,423	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	8,177,071	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)	8,177,071	40.00
40.01	Sequestration adjustment (see instructions)	163,541	40.01
41.00	Interim payments	8,108,701	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-95,171	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/20/2015 12:12 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		3,046,500		8,193,892	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	02/20/2015	30,397	02/20/2015	85,191	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)		-30,397		-85,191	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)		3,016,103		8,108,701	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		11,596		95,171	6.02
7.00	Total Medicare program liability (see instructions)		3,004,507		8,013,530	7.00

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G | Date/Time Prepared: 11/20/2015 12:12 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	0	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	0	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	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	0	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	0	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	0	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	0	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	0	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	0	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	0				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)	0	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	0	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-1 | Date/Time Prepared: 11/20/2015 12:12 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		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-647,316,470				2.00
3.00	Total (sum of line 1 and line 2)		-647,316,470		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-647,316,470		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-647,316,470		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: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/20/2015 12:12 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	0		0	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	0		0	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	0		0	17.00
18.00	Ancillary services	0	0	0	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	0	0	0	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		647,316,470		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		647,316,470		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140100 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-3 | Date/Time Prepared: 11/20/2015 12:12 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	0	1.00
2.00	Less contractual allowances and discounts on patients' accounts	0	2.00
3.00	Net patient revenues (line 1 minus line 2)	0	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	647,316,470	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-647,316,470	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	0	25.00
26.00	Total (line 5 plus line 25)	-647,316,470	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-647,316,470	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140100	Period: From 07/01/2014 To 06/30/2015	Worksheet L Parts I-III Date/Time Prepared: 11/20/2015 12:12 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	143,254	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	93,677	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)	32.06	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)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	236,931	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00