

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: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/25/2016 12:56 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 5/25/2016 Time: 12:56 pm	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ADVOCATE BROMENN MEDICAL CENTER (140127) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	191,553	9,481	-27,249	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	-11,025	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	180,528	9,481	-27,249	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140127		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 12:55 pm				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL		4.00 Zip Code: 61761-		County: MCLEAN		
1.00 Street: 1304 VIRGINIA		2.00 City: NORMAL								
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
3.00 Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ADVOCATE BROMENN MEDICAL CENTER	140127	14060	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	ADVOCATE BROMENN REHABILITATION	14T127	14060	5	07/01/1990	N	P	0	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 - FOHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2015	12/31/2015		20.00	
21.00	Type of Control (see instructions)					1		21.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3		N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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.	2,420	1,532	0	0	3,890	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.	48	42	0	0	114			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 12:55 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	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
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)				Y	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)			0.16	6.98	0.022409	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)	FAMILY PRACTICE - OSTEOPATHIC	3630	1.50	5.17	0.224888	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.25	9.51	0.025615		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)	FAMILY PRACTICE - OSTEOPATHIC	3630	0.01	6.77	0.001475
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		
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	
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y		
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N
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
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
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.					
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
				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.			Y	Y	
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	
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
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	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	

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		V		XIX				
		1.00		2.00				
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N			96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		97.00	
Rural Providers								
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N					105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N					106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N					107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N					108.00	
		Physical	Occupational	Speech	Respiratory			
		1.00	2.00	3.00	4.00			
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00	
						1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.					N	110.00	
						1.00	2.00	3.00
Miscellaneous Cost Reporting Information								
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0		115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N					117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00	
		Premiums	Losses	Insurance				
		1.00	2.00	3.00				
118.01	List amounts of malpractice premiums and paid losses:	166,524	250,500	869,593			118.01	
						1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.					N		118.02
119.00	DO NOT USE THIS LINE							119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N			120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.					Y		121.00
Transplant Center Information								
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.					N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 12:55 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	14H036	140.00			
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: ADVOCATE HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 00130			
142.00	Street: 3075 HIGHLAND PKWY	PO Box: SUITE 600					
143.00	City: DOWNERS GROVE	State: IL		Zip Code: 60515			
				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	
161.10	CORF		N	N	N	161.10	
				1.00			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00			
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y		167.00			
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0		168.00			
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01			
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.25		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)	01/01/2015		12/31/2015		170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 12:55 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: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/25/2016 12:55 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/06/2015	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	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.	Y			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)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/16/2016	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/25/2016 12:55 pm
	Description	Part A		Part B
		Y/N	Date	Y/N
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	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.	PAMELA	DYE	41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVOCATE HEALTHCARE		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-929-5760	PAMELA.DYE@ADVOCATEHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/25/2016 12:55 pm
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		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	03/16/2016		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		SENIOR REIMBURSEMENT SPECIALIST	41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HFS Supplemental Information		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part IX Date/Time Prepared: 5/25/2016 12:55 pm	
			Title V	Title XIX	
			1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	3.00
			Inpatient	Outpatient	
			1.00	2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	5.00
			Title V	Title XIX	
			1.00	2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	6.00
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	7.00
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	8.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140127

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

Worksheet S-3
Part I
Date/Time Prepared:
5/25/2016 12:55 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	176	64,240	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)		176	64,240	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	30	10,950	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		206	75,190	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	15	5,475		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		221				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: 140127

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

Worksheet S-3
Part I
Date/Time Prepared:
5/25/2016 12:55 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,061	2,031	21,367			1.00
2.00 HMO and other (see instructions)	3,794	3,890				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	114				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)	7,061	2,031	21,367			7.00
8.00 INTENSIVE CARE UNIT	2,929	434	7,780			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		1,324	4,228			13.00
14.00 Total (see instructions)	9,990	3,789	33,375	12.57	912.07	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF	1,762	90	2,923	0.00	15.72	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	0.00	24.00
24.10 HOSPICE (non-distinct part)	0	0	132			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				12.57	927.79	27.00
28.00 Observation Bed Days		172	2,763			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			437			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	163	416			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			44			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140127

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

Worksheet S-3
Part I
Date/Time Prepared:
5/25/2016 12:55 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,358	822	8,222	1.00
2.00 HMO and other (see instructions)			934	1,126		2.00
3.00 HMO IPF Subprovider				9		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,358	822	8,222	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0	164	8	258	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC						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: 140127		Period: From 01/01/2015 To 12/31/2015		Worksheet S-3 Part II Date/Time Prepared: 5/25/2016 12:55 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	55,195,575	0	55,195,575	1,929,803.00	28.60	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		132,484	0	132,484	851.00	155.68	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		12,200	0	12,200	1.00	12,200.00	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	1,399,760	0	1,399,760	50,773.00	27.57	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)		2,248,809	-67,524	2,181,285	100,713.00	21.66	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		857,410	0	857,410	9,885.00	86.74	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		2,001,228	0	2,001,228	22,335.00	89.60	13.00
14.00	Home office salaries & wage-related costs		5,573,351	0	5,573,351	89,087.00	62.56	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		13,607,314	0	13,607,314			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		596,882	0	596,882			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		26,739	0	26,739			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		3,322	0	3,322			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		381,157	0	381,157			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	1,507,770	-1,261,130	246,640	10,754.00	22.93	26.00
27.00	Administrative & General	5.00	6,415,553	894,304	7,309,857	215,843.00	33.87	27.00
28.00	Administrative & General under contract (see inst.)		1,939,772	0	1,939,772	56,539.00	34.31	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,230,318	11,618	1,241,936	42,254.00	29.39	30.00
31.00	Laundry & Linen Service	8.00	314,280	-8,863	305,417	25,198.00	12.12	31.00
32.00	Housekeeping	9.00	1,130,454	15,239	1,145,693	88,670.00	12.92	32.00
33.00	Housekeeping under contract (see instructions)		1,250	0	1,250	17.00	73.53	33.00
34.00	Dietary	10.00	939,661	-449,454	490,207	32,161.00	15.24	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	459,833	459,833	31,840.00	14.44	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,785,133	114,584	1,899,717	44,075.00	43.10	38.00
39.00	Central Services and Supply	14.00	328,452	3,304	331,756	21,112.00	15.71	39.00
40.00	Pharmacy	15.00	2,140,210	27,308	2,167,518	51,613.00	42.00	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140127

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

Worksheet S-3
Part II
Date/Time Prepared:
5/25/2016 12:55 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
41.00	Medical Records & Medical Records Library	16.00	1,244,218	8,632	1,252,850	51,438.00	24.36	41.00
42.00	Social Service	17.00	1,095,494	4,277	1,099,771	30,160.00	36.46	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140127

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

Worksheet S-3
Part III
Date/Time Prepared:
5/25/2016 12:55 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	55,724,637	0	55,724,637	1,935,585.00	28.79	1.00
2.00	Excluded area salaries (see instructions)	2,248,809	-67,524	2,181,285	100,713.00	21.66	2.00
3.00	Subtotal salaries (line 1 minus line 2)	53,475,828	67,524	53,543,352	1,834,872.00	29.18	3.00
4.00	Subtotal other wages & related costs (see inst.)	8,431,989	0	8,431,989	121,307.00	69.51	4.00
5.00	Subtotal wage-related costs (see inst.)	13,634,053	0	13,634,053	0.00	25.46	5.00
6.00	Total (sum of lines 3 thru 5)	75,541,870	67,524	75,609,394	1,956,179.00	38.65	6.00
7.00	Total overhead cost (see instructions)	20,072,565	-180,348	19,892,217	701,674.00	28.35	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part IV Date/Time Prepared: 5/25/2016 12:55 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			1,208,460 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			1,795,525 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			112,510 6.00
7.00	Employee Managed Care Program Administration Fees			516,591 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			3,400,615 8.00
9.00	Prescription Drug Plan			1,684,386 9.00
10.00	Dental, Hearing and Vision Plan			185,711 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			83,300 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			346,913 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			1,310,276 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			3,889,862 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			55,278 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			231,532 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			208,900 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			15,029,859 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS(SPECIFY)			134,756 25.00

WAGE INDEX PENSION COST SCHEDULE		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part IV Exhibit 3 Date/Time Prepared: 5/25/2016 12:55 pm
				1.00
1.00	Step 1: Determine the 3-Year Averaging Period Wage Index FY ending.			2019 1.00
				From To
				1.00 2.00
2.00	Provider cost reporting period used for Wage Index year shown on Line 1.			01/01/2015 12/31/2015 2.00
3.00	End of the 3-year averaging period (Final date from cost reporting period shown on Line 2.)			12/31/2015 3.00
4.00	Beginning of the 3-year averaging period (Subtract 36 months from End date shown on Line 3)			01/01/2013 4.00
Step 2: Adjust Averaging Period for a New Plan (See Instructions) (Leave this section blank if the provider has not elected to use an adjusted averaging period)				
5.00	Effective date of pension plan			5.00
6.00	First day of the provider cost reporting period containing the pension plan effective date			6.00
Step 3: Average Pension Contribution During the Averaging Period				
7.00	Beginning date of averaging period from Line 4 or Line 6			01/01/2013 7.00
8.00	Ending date of averaging period from Line 3			12/31/2015 8.00
				Deposit Date Contributions
				1.00 2.00
9.00	Enter provider contributions made during the averaging period shown on lines 7 & 8. Add additional lines as necessary if more than 15 contributions are made during the cost reporting period. (Data may be grouped within the averaging period to agree with documentation records (enter beginning date of grouped date range))			9.00
9.01				07/01/2015 2,703,367 9.01
9.02				07/01/2014 1,276,508 9.02
9.03				07/01/2013 1,406,701 9.03
				1.00
10.00	Total Number of Months Included in Averaging Period			36 10.00
11.00	Total Contributions Made During Averaging Period			5,386,576 11.00
12.00	Average Monthly Contribution. (Line 11 divided by line 10)			149,627 12.00
13.00	Number of Months in Provider Cost Reporting Period shown on Line 2			12 13.00
14.00	Average Pension Contributions (Line 12 multiplied by Line 13)			1,795,524 14.00
Step 4: Total Pension Cost for Wage Index (If the Wage Index FY shown on Line 1 is after 2022, enter "0" on Lines 15 and 16.)				
15.00	Annual Prefunding Installment from Line 8 of Pension Prefunding Worksheet, if applicable (see instructions)			12 15.00
16.00	Reportable Prefunding Installment (Line 15 multiplied by Line 13/12)			12 16.00
17.00	Total Pension Cost for Wage Index (Line 14 + Line 16)			1,795,536 17.00
				Prepared By Date
				1.00 2.00
100.00	Prepared By and Date Prepared			DAVE STRIEPLING 04/29/2016 100.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part V Date/Time Prepared: 5/25/2016 12:55 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		857,410	15,029,858
2.00	Hospital		857,410	14,021,758
3.00	Subprovider - IPF		0	0
4.00	Subprovider - IRF		0	240,847
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA		0	0
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice		0	0
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
16.10	Hospital-Based-CMHC 10		0	0
17.00	Renal Dialysis			
18.00	Other		0	767,253

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 5/25/2016 12:55 pm
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				1.00		
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.286741		1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		17,978,354		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		72,230,136		6.00	
7.00	Medicaid cost (line 1 times line 6)		20,711,341		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)		2,732,987		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)		2,732,987		19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility		6,020,365	7,238,821	13,259,186	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		1,726,285	2,075,667	3,801,952	21.00
22.00	Partial payment by patients approved for charity care		15,161	109,233	124,394	22.00
23.00	Cost of charity care (line 21 minus line 22)		1,711,124	1,966,434	3,677,558	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?					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)				10,099,455	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)				436,384	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)				9,663,071	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)				2,770,799	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				6,448,357	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				9,181,344	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 140127		Period: From 01/01/2015 To 12/31/2015		Worksheet A	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		5,307,645		5,307,645	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	5,703,791	5,703,791	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,507,770	10,834,427	12,342,197	-1,396,176	10,946,021
5.00	00500	ADMINISTRATIVE & GENERAL	6,415,553	40,036,783	46,452,336	-76,702	46,375,634
7.00	00700	OPERATION OF PLANT	1,230,318	4,070,432	5,300,750	-269,664	5,031,086
8.00	00800	LAUNDRY & LINEN SERVICE	314,280	331,948	646,228	-75,463	570,765
9.00	00900	HOUSEKEEPING	1,130,454	759,826	1,890,280	-2,850	1,887,430
10.00	01000	DIETARY	939,661	840,115	1,779,776	-899,513	880,263
11.00	01100	CAFETERIA	0	0	0	866,826	866,826
13.00	01300	NURSING ADMINISTRATION	1,785,133	209,807	1,994,940	104,366	2,099,306
14.00	01400	CENTRAL SERVICES & SUPPLY	328,452	763,330	1,091,782	-436,169	655,613
15.00	01500	PHARMACY	2,140,210	6,196,077	8,336,287	-158,398	8,177,889
16.00	01600	MEDICAL RECORDS & LIBRARY	1,244,218	595,399	1,839,617	-4,860	1,834,757
17.00	01700	SOCIAL SERVICE	1,095,494	291,148	1,386,642	4,277	1,390,919
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,399,760	321,751	1,721,511	12,700	1,734,211
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	5,842	5,842
23.00	02300	CLINICAL PASTORAL EDUCATION	343,554	52,894	396,448	-78,258	318,190
23.01	02301	EMS PROGRAM	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,147,530	6,045,797	18,193,327	-3,179,461	15,013,866
31.00	03100	INTENSIVE CARE UNIT	3,430,225	1,393,387	4,823,612	-697,389	4,126,223
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0
41.00	04100	SUBPROVIDER - I RF	893,801	153,525	1,047,326	53,361	1,100,687
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	1,860,434	1,860,434
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,163,254	15,153,879	18,317,133	-12,198,805	6,118,328
51.00	05100	RECOVERY ROOM	639,904	81,877	721,781	-19,646	702,135
53.00	05300	ANESTHESIOLOGY	42,621	370,879	413,500	-327,633	85,867
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,410,824	1,906,113	4,316,937	-1,183,329	3,133,608
57.00	05700	CT SCAN	422,437	478,274	900,711	-385,103	515,608
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	1,973,961	3,162,429	5,136,390	-2,046,588	3,089,802
65.00	06500	RESPIRATORY THERAPY	845,924	225,211	1,071,135	-139,968	931,167
66.00	06600	PHYSICAL THERAPY	1,216,456	291,006	1,507,462	-48,420	1,459,042
67.00	06700	OCCUPATIONAL THERAPY	280,905	27,211	308,116	-3,661	304,455
68.00	06800	SPEECH PATHOLOGY	223,863	19,347	243,210	52	243,262
69.00	06900	ELECTROCARDIOLOGY	1,609,026	3,996,779	5,605,805	-3,741,615	1,864,190
70.00	07000	ELECTROENCEPHALOGRAPHY	77,310	86,771	164,081	-8,714	155,367
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,114,400	10,114,400
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	9,746,155	9,746,155
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	342,077	47,670	389,747	-11,895	377,852
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	570,289	85,089	655,378	-9,263	646,115
90.01	09001	BASIC DIAGNOSTIC TESTING	439,365	50,886	490,251	-490,251	0
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0
90.04	09003	WOUND CARE CLINIC	461,767	715,185	1,176,952	-176,956	999,996
91.00	09100	EMERGENCY	3,117,725	858,664	3,976,389	-441,692	3,534,697
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE		4,916,027	4,916,027	0	4,916,027
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	54,184,121	110,677,588	164,861,709	-36,238	164,825,471
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	380,283	691,377	1,071,660	-7,062	1,064,598
190.01	19001	OTHER NONREIMBURSABLE	631,171	1,821,644	2,452,815	43,300	2,496,115
190.13	19007	EUREKA	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
200.00		TOTAL (SUM OF LINES 118-199)	55,195,575	113,190,609	168,386,184	0	168,386,184

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140127

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

Worksheet A
Date/Time Prepared:
5/25/2016 12:55 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	981,324	6,288,969	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,058,741	6,762,532	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-399,530	10,546,491	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-21,340,090	25,035,544	5.00
7.00	00700	OPERATION OF PLANT	408,816	5,439,902	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-226,934	343,831	8.00
9.00	00900	HOUSEKEEPING	-36,573	1,850,857	9.00
10.00	01000	DIETARY	-687	879,576	10.00
11.00	01100	CAFETERIA	-428,618	438,208	11.00
13.00	01300	NURSING ADMINISTRATION	-31,526	2,067,780	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	655,613	14.00
15.00	01500	PHARMACY	-82,963	8,094,926	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,745	1,826,012	16.00
17.00	01700	SOCIAL SERVICE	0	1,390,919	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,734,211	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	-8,678	-2,836	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	-8,495	309,695	23.00
23.01	02301	EMS PROGRAM	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,849,596	13,164,270	30.00
31.00	03100	INTENSIVE CARE UNIT	-188	4,126,035	31.00
40.00	04000	SUBPROVIDER - I PF	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	-126	1,100,561	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	-4,200	1,856,234	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-801,346	5,316,982	50.00
51.00	05100	RECOVERY ROOM	0	702,135	51.00
53.00	05300	ANESTHESIOLOGY	0	85,867	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-35,541	3,098,067	54.00
57.00	05700	CT SCAN	-12,200	503,408	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-274,096	2,815,706	60.00
65.00	06500	RESPIRATORY THERAPY	-35	931,132	65.00
66.00	06600	PHYSICAL THERAPY	-54,993	1,404,049	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	304,455	67.00
68.00	06800	SPEECH PATHOLOGY	-32	243,230	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,864,190	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	155,367	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,114,400	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	9,746,155	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	-20	377,832	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-690	645,425	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0	999,996	90.04
91.00	09100	EMERGENCY	-137	3,534,560	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	-4,916,027	0	113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-28,073,185	136,752,286	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,064,598	190.00
190.01	19001	OTHER NONREIMBURSABLE	0	2,496,115	190.01
190.13	19007	EUREKA	0	0	190.13
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	-28,073,185	140,312,999	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet Non-CMS W
Date/Time Prepared: 5/25/2016 12:55 pm				
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAPITAL RELATED COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	02100		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	02200		22.00
23.00	CLINICAL PASTORAL EDUCATION	02300		23.00
23.01	EMS PROGRAM	02301		23.01
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
41.00	SUBPROVIDER - IRF	04100		41.00
42.00	SUBPROVIDER	04200		42.00
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
90.01	BASIC DIAGNOSTIC TESTING	09001		90.01
90.03	PSYCH OUTPATIENT	09002		90.03
90.04	WOUND CARE CLINIC	09003		90.04
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
93.00	OTHER OUTPATIENT SERVICES	04040	FAMILY PRACTICE	93.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	09910		99.10
101.00	HOME HEALTH AGENCY	10100		101.00
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	10900		109.00
110.00	INTESTINAL ACQUISITION	11000		110.00
111.00	ISLET ACQUISITION	11100		111.00
113.00	INTEREST EXPENSE	11300		113.00
116.00	HOSPICE	11600		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
190.01	OTHER NONREIMBURSABLE	19001		190.01
190.13	EUREKA	19007		190.13
191.00	RESEARCH	19100		191.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140127

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

Worksheet A-6

Date/Time Prepared:
5/25/2016 12:55 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - NURSERY EXPENSE					
1.00	NURSERY	43.00	2,040,090	181,761	1.00
	TOTALS		2,040,090	181,761	
B - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	454,670	406,993	1.00
	TOTALS		454,670	406,993	
C - MEDICAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	19,860,555	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	13,554	2.00
3.00	OTHER NONREIMBURSABLE	190.01	0	56,383	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
	TOTALS		0	19,930,492	
D - MANAGEMENT COMPENSATION RECLASS					
1.00		0.00	0	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	698,716	0	2.00
3.00	OPERATION OF PLANT	7.00	15,506	0	3.00
4.00	NURSING ADMINISTRATION	13.00	101,331	0	4.00
5.00	PHARMACY	15.00	26,998	0	5.00
6.00	CLINICAL PASTORAL EDUCATION	23.00	6,676	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	24,589	0	7.00
8.00	NURSERY	43.00	4,143	0	8.00
9.00	OPERATING ROOM	50.00	23,163	0	9.00
10.00	RECOVERY ROOM	51.00	7,305	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	13,655	0	11.00
12.00	LABORATORY	60.00	8,677	0	12.00
13.00	RESPIRATORY THERAPY	65.00	6,888	0	13.00
14.00	PHYSICAL THERAPY	66.00	9,232	0	14.00
15.00	ELECTROCARDIOLOGY	69.00	1,768	0	15.00
16.00	EMERGENCY	91.00	8,239	0	16.00
	TOTALS		956,886	0	
E - IMPLANT RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	9,746,155	1.00
	TOTALS		0	9,746,155	
F - EQUIP DEPR EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	5,761,584	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00

RECLASSIFICATIONS

Provider CCN: 140127

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

Worksheet A-6
Date/Time Prepared:
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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
TOTALS			0	5,761,584	
G - BASIC DIAGNOSTIC TESTING					
1.00	OPERATING ROOM	50.00	413,003	45,982	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	4,394	489	2.00
3.00	LABORATORY	60.00	13,181	1,468	3.00
4.00	ELECTROCARDIOLOGY	69.00	8,787	978	4.00
TOTALS			439,365	48,917	
H - RECLASS EUREKA ALLOCATED COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	70,661	194,041	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
TOTALS			70,661	194,041	
I - A&G RELATED CPE COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	85,977	0	1.00
TOTALS			85,977	0	
J - RECLASS MD CONTRACT EXPENSES					
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	12,700	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	26,562	2.00
3.00	SUBPROVIDER - IRF	41.00	0	98,000	3.00
4.00	OPERATING ROOM	50.00	0	200,000	4.00
5.00	WOUND CARE CLINIC	90.04	0	13,000	5.00
TOTALS			0	350,262	
K - ASSOCIATE BONUS					
1.00	ADMINISTRATIVE & GENERAL	5.00	38,950	0	1.00
2.00	OPERATION OF PLANT	7.00	7,699	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	4,199	0	3.00
4.00	HOUSEKEEPING	9.00	15,239	0	4.00
5.00	DIETARY	10.00	5,216	0	5.00
6.00	CAFETERIA	11.00	5,163	0	6.00
7.00	NURSING ADMINISTRATION	13.00	13,253	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	3,304	0	8.00
9.00	PHARMACY	15.00	9,214	0	9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	8,632	0	10.00
11.00	SOCIAL SERVICE	17.00	4,277	0	11.00
12.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	7,426	0	12.00
13.00	CLINICAL PASTORAL EDUCATION	23.00	2,293	0	13.00
14.00	ADULTS & PEDIATRICS	30.00	49,412	0	14.00
15.00	INTENSIVE CARE UNIT	31.00	18,384	0	15.00
16.00	SUBPROVIDER - IRF	41.00	3,537	0	16.00
17.00	NURSERY	43.00	11,491	0	17.00
18.00	OPERATING ROOM	50.00	18,971	0	18.00
19.00	RECOVERY ROOM	51.00	2,682	0	19.00
20.00	ANESTHESIOLOGY	53.00	272	0	20.00

RECLASSIFICATIONS

Provider CCN: 140127

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

Worksheet A-6

Date/Time Prepared:
5/25/2016 12:55 pm

Increases						
Cost Center	Line #	Salary	Other			
2.00	3.00	4.00	5.00			
21.00	RADIOLOGY-DIAGNOSTIC	54.00	10,496	0		21.00
22.00	CT SCAN	57.00	1,749	0		22.00
23.00	LABORATORY	60.00	14,225	0		23.00
24.00	RESPIRATORY THERAPY	65.00	4,548	0		24.00
25.00	PHYSICAL THERAPY	66.00	5,209	0		25.00
26.00	OCCUPATIONAL THERAPY	67.00	1,749	0		26.00
27.00	SPEECH PATHOLOGY	68.00	1,127	0		27.00
28.00	ELECTROCARDIOLOGY	69.00	6,608	0		28.00
29.00	ELECTROENCEPHALOGRAPHY	70.00	505	0		29.00
30.00	CARDIAC REHABILITATION	76.97	2,099	0		30.00
31.00	CLINIC	90.00	1,944	0		31.00
32.00	WOUND CARE CLINIC	90.04	2,604	0		32.00
33.00	EMERGENCY	91.00	15,820	0		33.00
34.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	190.00	4,198	0		34.00
35.00	OTHER NONREIMBURSABLE	190.01	1,749	0		35.00
	TOTALS		304,244	0		
500.00	Grand Total: Increases		4,351,893	36,620,205		500.00

RECLASSIFICATIONS

Provider CCN: 140127

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

Worksheet A-6
Date/Time Prepared:
5/25/2016 12:55 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - NURSERY EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	2,040,090	181,761	0	1.00
	TOTALS		2,040,090	181,761		
B - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	454,670	406,993	0	1.00
	TOTALS		454,670	406,993		
C - MEDICAL SUPPLY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9,804	0	1.00
2.00	OPERATION OF PLANT	7.00	0	116,390	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	8,317	0	3.00
4.00	HOUSEKEEPING	9.00	0	6,565	0	4.00
5.00	DIETARY	10.00	0	10,163	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	3,110	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	395,193	0	7.00
8.00	PHARMACY	15.00	0	80,005	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	26	0	9.00
11.00	ADULTS & PEDIATRICS	30.00	0	646,837	0	11.00
12.00	INTENSIVE CARE UNIT	31.00	0	368,279	0	12.00
13.00	SUBPROVIDER - IRF	41.00	0	47,494	0	13.00
14.00	NURSERY	43.00	0	181,042	0	14.00
15.00	OPERATING ROOM	50.00	0	11,794,799	0	15.00
16.00	RECOVERY ROOM	51.00	0	17,863	0	16.00
17.00	ANESTHESIOLOGY	53.00	0	323,133	0	17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	343,540	0	18.00
19.00	CT SCAN	57.00	0	146,736	0	19.00
20.00	LABORATORY	60.00	0	1,916,742	0	20.00
21.00	RESPIRATORY THERAPY	65.00	0	117,450	0	21.00
22.00	PHYSICAL THERAPY	66.00	0	15,531	0	22.00
23.00	OCCUPATIONAL THERAPY	67.00	0	5,410	0	23.00
24.00	SPEECH PATHOLOGY	68.00	0	737	0	24.00
25.00	ELECTROCARDIOLOGY	69.00	0	2,812,763	0	25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,413	0	26.00
27.00	CARDIAC REHABILITATION	76.97	0	5,106	0	27.00
28.00	CLINIC	90.00	0	9,973	0	28.00
29.00	WOUND CARE CLINIC	90.04	0	191,746	0	29.00
30.00	EMERGENCY	91.00	0	349,718	0	30.00
31.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	1,638	0	31.00
32.00	BASIC DIAGNOSTIC TESTING	90.01	0	1,969	0	32.00
	TOTALS		0	19,930,492		
D - MANAGEMENT COMPENSATION RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	956,886	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
	TOTALS		956,886	0		
E - IMPLANT RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	9,746,155	0	1.00
	TOTALS		0	9,746,155		
F - EQUIP DEPR EXPENSE						
1.00		0.00	0	0	9	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	828,339	0	2.00
3.00	OPERATION OF PLANT	7.00	0	164,892	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	44,487	0	4.00
5.00	HOUSEKEEPING	9.00	0	11,524	0	5.00
6.00	DIETARY	10.00	0	32,903	0	6.00
7.00	NURSING ADMINISTRATION	13.00	0	7,108	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	44,280	0	8.00
9.00	PHARMACY	15.00	0	105,701	0	9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	13,466	0	10.00

RECLASSIFICATIONS

Provider CCN: 140127

Period:
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To 12/31/2015

Worksheet A-6
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
11.00	I&R SERVICES-OTHER PRGM	22.00	0	1,584	0	11.00	
	COSTS APPRVD						
12.00	CLINICAL PASTORAL EDUCATION	23.00	0	1,250	0	12.00	
13.00	ADULTS & PEDIATRICS	30.00	0	411,336	0	13.00	
14.00	INTENSIVE CARE UNIT	31.00	0	347,494	0	14.00	
15.00	SUBPROVIDER - IRF	41.00	0	682	0	15.00	
16.00	NURSERY	43.00	0	196,009	0	16.00	
17.00	OPERATING ROOM	50.00	0	1,105,125	0	17.00	
18.00	RECOVERY ROOM	51.00	0	11,770	0	18.00	
19.00	ANESTHESIOLOGY	53.00	0	4,772	0	19.00	
20.00	RADIOLOGY-DIAGNOSTIC	54.00	0	845,208	0	20.00	
21.00	CT SCAN	57.00	0	240,116	0	21.00	
22.00	LABORATORY	60.00	0	153,904	0	22.00	
23.00	RESPIRATORY THERAPY	65.00	0	33,954	0	23.00	
24.00	PHYSICAL THERAPY	66.00	0	47,330	0	24.00	
25.00	SPEECH PATHOLOGY	68.00	0	338	0	25.00	
26.00	ELECTROCARDIOLOGY	69.00	0	946,993	0	26.00	
27.00	ELECTROENCEPHALOGRAPHY	70.00	0	6,806	0	27.00	
28.00	CARDIAC REHABILITATION	76.97	0	8,888	0	28.00	
29.00	CLINIC	90.00	0	1,234	0	29.00	
30.00	WOUND CARE CLINIC	90.04	0	814	0	30.00	
31.00	EMERGENCY	91.00	0	116,033	0	31.00	
32.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	9,622	0	32.00	
33.00	OTHER NONREIMBURSABLE	190.01	0	14,832	0	33.00	
34.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,790	0	34.00	
	TOTALS		0	5,761,584			
G - BASIC DIAGNOSTIC TESTING							
1.00	BASIC DIAGNOSTIC TESTING	90.01	439,365	48,917	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	
	TOTALS		439,365	48,917			
H - RECLASS EUREKA ALLOCATED COSTS							
1.00		0.00	0	0	0	1.00	
2.00	OPERATION OF PLANT	7.00	11,587	0	0	2.00	
3.00	RADIOLOGY-DIAGNOSTIC	54.00	23,615	0	0	3.00	
4.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	122,452	0	4.00	
5.00	PHARMACY	15.00	8,904	0	0	5.00	
6.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	57,793	9	6.00	
7.00	LABORATORY	60.00	13,493	0	0	7.00	
8.00	LAUNDRY & LINEN SERVICE	8.00	13,062	13,796	0	8.00	
	TOTALS		70,661	194,041			
I - A&G RELATED CPE COSTS							
1.00	CLINICAL PASTORAL EDUCATION	23.00	85,977	0	0	1.00	
	TOTALS		85,977	0			
J - RECLASS MD CONTRACT EXPENSES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	350,262	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	
	TOTALS		0	350,262			
K - ASSOCIATE BONUS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	304,244	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	

RECLASSIFICATIONS

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Period:
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	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
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
27.00		0.00	0	0	0		27.00
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
33.00		0.00	0	0	0		33.00
34.00		0.00	0	0	0		34.00
35.00		0.00	0	0	0		35.00
	TOTALS		304,244		0		
500.00	Grand Total: Decreases		4,351,893	36,620,205			500.00

RECLASSIFICATIONS

Provider CCN: 140127

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

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
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Increases					Decreases				
Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
A - NURSERY EXPENSE									
1.00	NURSERY	43.00	2,040,090	181,761	ADULTS & PEDIATRICS	30.00	2,040,090	181,761	1.00
	TOTALS		2,040,090	181,761	TOTALS		2,040,090	181,761	
B - CAFETERIA EXPENSE									
1.00	CAFETERIA	11.00	454,670	406,993	DIETARY	10.00	454,670	406,993	1.00
	TOTALS		454,670	406,993	TOTALS		454,670	406,993	
C - MEDICAL SUPPLY RECLASS									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	19,860,555	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9,804	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	13,554	OPERATION OF PLANT	7.00	0	116,390	2.00
3.00	OTHER NONREIMBURSABLE	190.01	0	56,383	LAUNDRY & LINEN SERVICE	8.00	0	8,317	3.00
4.00		0.00	0		HOUSEKEEPING	9.00	0	6,565	4.00
5.00		0.00	0		DIETARY	10.00	0	10,163	5.00
6.00		0.00	0		NURSING	13.00	0	3,110	6.00
7.00		0.00	0		ADMINISTRATION				
8.00		0.00	0		CENTRAL SERVICES & SUPPLY	14.00	0	395,193	7.00
9.00		0.00	0		PHARMACY	15.00	0	80,005	8.00
		0.00	0		MEDICAL RECORDS & LIBRARY	16.00	0	26	9.00
11.00		0.00	0		ADULTS & PEDIATRICS	30.00	0	646,837	11.00
12.00		0.00	0		INTENSIVE CARE UNIT	31.00	0	368,279	12.00
13.00		0.00	0		SUBPROVIDER - IIRF	41.00	0	47,494	13.00
14.00		0.00	0		NURSERY	43.00	0	181,042	14.00
15.00		0.00	0		OPERATING ROOM	50.00	0	11,794,799	15.00
16.00		0.00	0		RECOVERY ROOM	51.00	0	17,863	16.00
17.00		0.00	0		ANESTHESIOLOGY	53.00	0	323,133	17.00
18.00		0.00	0		RADIOLOGY-DIAGNOSTIC	54.00	0	343,540	18.00
19.00		0.00	0		CT SCAN	57.00	0	146,736	19.00
20.00		0.00	0		LABORATORY	60.00	0	1,916,742	20.00
21.00		0.00	0		RESPIRATORY THERAPY	65.00	0	117,450	21.00
22.00		0.00	0		PHYSICAL THERAPY	66.00	0	15,531	22.00
23.00		0.00	0		OCCUPATIONAL THERAPY	67.00	0	5,410	23.00
24.00		0.00	0		SPEECH PATHOLOGY	68.00	0	737	24.00
25.00		0.00	0		ELECTROCARDIOLOGY	69.00	0	2,812,763	25.00
26.00		0.00	0		ELECTROENCEPHALOGRAPHY	70.00	0	2,413	26.00
27.00		0.00	0		CARDIAC REHABILITATION	76.97	0	5,106	27.00
28.00		0.00	0		CLINIC	90.00	0	9,973	28.00
29.00		0.00	0		WOUND CARE CLINIC	90.04	0	191,746	29.00
30.00		0.00	0		EMERGENCY	91.00	0	349,718	30.00
31.00		0.00	0		GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	1,638	31.00
32.00		0.00	0		BASIC DIAGNOSTIC TESTING	90.01	0	1,969	32.00
	TOTALS		0	19,930,492	TOTALS		0	19,930,492	
D - MANAGEMENT COMPENSATION RECLASS									
1.00		0.00	0	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	956,886	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	698,716	0		0.00	0	0	2.00
3.00	OPERATION OF PLANT	7.00	15,506	0		0.00	0	0	3.00
4.00	NURSING	13.00	101,331	0		0.00	0	0	4.00
5.00	ADMINISTRATION	15.00	26,998	0		0.00	0	0	5.00
6.00	PHARMACY	23.00	6,676	0		0.00	0	0	6.00
7.00	CLINICAL PASTORAL EDUCATION								
7.00	ADULTS & PEDIATRICS	30.00	24,589	0		0.00	0	0	7.00
8.00	NURSERY	43.00	4,143	0		0.00	0	0	8.00
9.00	OPERATING ROOM	50.00	23,163	0		0.00	0	0	9.00
10.00	RECOVERY ROOM	51.00	7,305	0		0.00	0	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	13,655	0		0.00	0	0	11.00
12.00	LABORATORY	60.00	8,677	0		0.00	0	0	12.00
13.00	RESPIRATORY THERAPY	65.00	6,888	0		0.00	0	0	13.00
14.00	PHYSICAL THERAPY	66.00	9,232	0		0.00	0	0	14.00
15.00	ELECTROCARDIOLOGY	69.00	1,768	0		0.00	0	0	15.00
16.00	EMERGENCY	91.00	8,239	0		0.00	0	0	16.00
	TOTALS		956,886	0	TOTALS		956,886	0	
E - IMPLANT RECLASS									
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	9,746,155	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	9,746,155	1.00
	TOTALS		0	9,746,155	TOTALS		0	9,746,155	

RECLASSIFICATIONS

Provider CCN: 140127

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

Worksheet A-6
Non-CMS Worksheet
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Increases				Decreases					
Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
F - EQUIP DEPR EXPENSE									
1.00	NEW CAP REL	2.00	0	5,761,584	0.00	0	0	1.00	
2.00	COSTS-MVBLE EQUIP	0.00	0		0	0	828,339	2.00	
3.00		0.00	0		0	0	164,892	3.00	
4.00		0.00	0		0	0	44,487	4.00	
5.00		0.00	0		0	0	11,524	5.00	
6.00		0.00	0		0	0	32,903	6.00	
7.00		0.00	0		0	0	7,108	7.00	
8.00		0.00	0		0	0	44,280	8.00	
9.00		0.00	0		0	0	105,701	9.00	
10.00		0.00	0		0	0	13,466	10.00	
11.00		0.00	0		0	0	1,584	11.00	
12.00		0.00	0		0	0	1,250	12.00	
13.00		0.00	0		0	0	411,336	13.00	
14.00		0.00	0		0	0	347,494	14.00	
15.00		0.00	0		0	0	682	15.00	
16.00		0.00	0		0	0	196,009	16.00	
17.00		0.00	0		0	0	1,105,125	17.00	
18.00		0.00	0		0	0	11,770	18.00	
19.00		0.00	0		0	0	4,772	19.00	
20.00		0.00	0		0	0	845,208	20.00	
21.00		0.00	0		0	0	240,116	21.00	
22.00		0.00	0		0	0	153,904	22.00	
23.00		0.00	0		0	0	33,954	23.00	
24.00		0.00	0		0	0	47,330	24.00	
25.00		0.00	0		0	0	338	25.00	
26.00		0.00	0		0	0	946,993	26.00	
27.00		0.00	0		0	0	6,806	27.00	
28.00		0.00	0		0	0	8,888	28.00	
29.00		0.00	0		0	0	1,234	29.00	
30.00		0.00	0		0	0	814	30.00	
31.00		0.00	0		0	0	116,033	31.00	
32.00		0.00	0		0	0	9,622	32.00	
33.00		0.00	0		0	0	14,832	33.00	
34.00		0.00	0		0	0	2,790	34.00	
	TOTALS		0	5,761,584	TOTALS		0	5,761,584	
G - BASIC DIAGNOSTIC TESTING									
1.00	OPERATING ROOM	50.00	413,003	45,982	BASIC DIAGNOSTIC TESTING	90.01	439,365	48,917	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	4,394	489		0.00	0	0	2.00
3.00	LABORATORY	60.00	13,181	1,468		0.00	0	0	3.00
4.00	ELECTROCARDIOLOGY	69.00	8,787	978		0.00	0	0	4.00
	TOTALS		439,365	48,917	TOTALS		439,365	48,917	
H - RECLASS EUREKA ALLOCATED COSTS									
1.00	ADMINISTRATIVE & GENERAL	5.00	70,661	194,041		0.00	0	0	1.00
2.00		0.00	0		0	0	11,587	0	2.00
3.00		0.00	0		0	0	23,615	0	3.00
4.00		0.00	0		0	0	122,452	0	4.00
5.00		0.00	0		0	0	8,904	0	5.00
6.00		0.00	0		0	0	57,793	0	6.00
7.00		0.00	0		0	0	13,493	0	7.00
8.00		0.00	0		0	0	13,062	13,796	8.00
	TOTALS		70,661	194,041	TOTALS		70,661	194,041	
I - A&G RELATED CPE COSTS									
1.00	ADMINISTRATIVE & GENERAL	5.00	85,977		0	0	85,977	0	1.00
	TOTALS		85,977		0	0	85,977	0	

RECLASSIFICATIONS

Provider CCN: 140127

Period:
From 01/01/2015
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Worksheet A-6
Non-CMS Worksheet
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Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
J - RECLASS MD CONTRACT EXPENSES									
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	12,700	ADMINISTRATIVE & GENERAL	5.00	0	350,262	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	26,562		0.00	0	0	2.00
3.00	SUBPROVIDER - IRF	41.00	0	98,000		0.00	0	0	3.00
4.00	OPERATING ROOM	50.00	0	200,000		0.00	0	0	4.00
5.00	WOUND CARE CLINIC	90.04	0	13,000		0.00	0	0	5.00
	TOTALS		0	350,262	TOTALS		0	350,262	
K - ASSOCIATE BONUS									
1.00	ADMINISTRATIVE & GENERAL	5.00	38,950	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	304,244	0	1.00
2.00	OPERATION OF PLANT	7.00	7,699	0		0.00	0	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	4,199	0		0.00	0	0	3.00
4.00	HOUSEKEEPING	9.00	15,239	0		0.00	0	0	4.00
5.00	DIETARY	10.00	5,216	0		0.00	0	0	5.00
6.00	CAFETERIA	11.00	5,163	0		0.00	0	0	6.00
7.00	NURSING	13.00	13,253	0		0.00	0	0	7.00
8.00	ADMINISTRATION	14.00	3,304	0		0.00	0	0	8.00
9.00	CENTRAL SERVICES & SUPPLY	15.00	9,214	0		0.00	0	0	9.00
10.00	PHARMACY	16.00	8,632	0		0.00	0	0	10.00
11.00	MEDICAL RECORDS & LIBRARY	17.00	4,277	0		0.00	0	0	11.00
12.00	SOCIAL SERVICE	22.00	7,426	0		0.00	0	0	12.00
13.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	23.00	2,293	0		0.00	0	0	13.00
14.00	CLINICAL PASTORAL EDUCATION	30.00	49,412	0		0.00	0	0	14.00
15.00	ADULTS & PEDIATRICS	31.00	18,384	0		0.00	0	0	15.00
16.00	INTENSIVE CARE UNIT	41.00	3,537	0		0.00	0	0	16.00
17.00	SUBPROVIDER - IRF	43.00	11,491	0		0.00	0	0	17.00
18.00	NURSERY	50.00	18,971	0		0.00	0	0	18.00
19.00	OPERATING ROOM	51.00	2,682	0		0.00	0	0	19.00
20.00	RECOVERY ROOM	53.00	272	0		0.00	0	0	20.00
21.00	ANESTHESIOLOGY	54.00	10,496	0		0.00	0	0	21.00
22.00	RADIOLOGY-DIAGNOSTIC	57.00	1,749	0		0.00	0	0	22.00
23.00	CT SCAN	60.00	14,225	0		0.00	0	0	23.00
24.00	LABORATORY	65.00	4,548	0		0.00	0	0	24.00
25.00	RESPIRATORY THERAPY	66.00	5,209	0		0.00	0	0	25.00
26.00	PHYSICAL THERAPY	67.00	1,749	0		0.00	0	0	26.00
27.00	OCCUPATIONAL THERAPY	68.00	1,127	0		0.00	0	0	27.00
28.00	SPEECH PATHOLOGY	69.00	6,608	0		0.00	0	0	28.00
29.00	ELECTROCARDIOLOGY	70.00	505	0		0.00	0	0	29.00
30.00	ELECTROENCEPHALOGRAPHY	76.97	2,099	0		0.00	0	0	30.00
31.00	CARDIAC REHABILITATION CLINIC	90.00	1,944	0		0.00	0	0	31.00
32.00	WOUND CARE CLINIC	90.04	2,604	0		0.00	0	0	32.00
33.00	EMERGENCY	91.00	15,820	0		0.00	0	0	33.00
34.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	190.00	4,198	0		0.00	0	0	34.00
35.00	OTHER NONREIMBURSABLE	190.01	1,749	0		0.00	0	0	35.00
	TOTALS		304,244	0	TOTALS		304,244	0	
500.00	Grand Total : Increases		4,351,893	36,620,205	Grand Total : Decreases		4,351,893	36,620,205	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140127

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

Worksheet A-7
Part I
Date/Time Prepared:
5/25/2016 12:55 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	7,844,000	0	0	0	1.00
2.00	Land Improvements	9,768,085	57,121	0	57,121	2.00
3.00	Buildings and Fixtures	231,007,468	5,005,050	0	5,005,050	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	95,642,218	3,379,669	0	3,379,669	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	344,261,771	8,441,840	0	8,441,840	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	344,261,771	8,441,840	0	8,441,840	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	7,844,000	0			1.00
2.00	Land Improvements	9,825,206	4,415,348			2.00
3.00	Buildings and Fixtures	235,901,711	117,460,453			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	97,540,292	45,696,049			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	351,111,209	167,571,850			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	351,111,209	167,571,850			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140127

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

Worksheet A-7
Part II
Date/Time Prepared:
5/25/2016 12:55 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	NEW CAP REL COSTS-BLDG & FIXT	5,307,645	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,307,645	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5,307,645				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	5,307,645				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140127

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

Worksheet A-7
Part III
Date/Time Prepared:
5/25/2016 12:55 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	248,619,553	0	248,619,553	0.722182	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	95,642,218	0	95,642,218	0.277818	0	2.00
3.00	Total (sum of lines 1-2)	344,261,771	0	344,261,771	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	6,288,969	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	6,762,532	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	13,051,501	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	6,288,969	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	6,762,532	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	13,051,501	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140127

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

Worksheet A-8

Date/Time Prepared:
5/25/2016 12:55 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-7,015,783			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	-5,195,707			0	12.00
13.00 Laundry and linen service	B	-226,934	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00 Cafeteria-employees and guests	B	-428,618	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients	B	-82,392	PHARMACY	15.00	0	17.00
18.00 Sale of medical records and abstracts	B	-8,710	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0	0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)	B	-66,000	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140127

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

Worksheet A-8

Date/Time Prepared:
5/25/2016 12:55 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.00	MI SCCELLANEOUS INCOME	B	-9,229	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.00
33.03	MI SCCELLANEOUS INCOME	B	-152,544	ADMINISTRATIVE & GENERAL	5.00	0 33.03
33.04	MI SCCELLANEOUS INCOME	B	-669	OPERATION OF PLANT	7.00	0 33.04
33.08	MI SCCELLANEOUS INCOME	B	-36,271	HOUSEKEEPING	9.00	0 33.08
33.09	MI SCCELLANEOUS INCOME	B	-31,526	NURSING ADMINISTRATION	13.00	0 33.09
33.10	MI SCCELLANEOUS INCOME	B	-156	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0 33.10
33.19	MI SCCELLANEOUS INCOME	B	-7,343	CLINICAL PASTORAL EDUCATION	23.00	0 33.19
33.20	MI SCCELLANEOUS INCOME	B	-3,715	ADULTS & PEDIATRICS	30.00	0 33.20
33.21	MI SCCELLANEOUS INCOME	B	-4,200	NURSERY	43.00	0 33.21
33.22	MI SCCELLANEOUS INCOME	B	-1,000	OPERATING ROOM	50.00	0 33.22
33.24	MI SCCELLANEOUS INCOME	B	-11,636	RADIOLOGY-DIAGNOSTIC	54.00	0 33.24
33.25	MI SCCELLANEOUS INCOME	B	-274,096	LABORATORY	60.00	0 33.25
33.28	MI SCCELLANEOUS INCOME	B	-54,895	PHYSICAL THERAPY	66.00	0 33.28
34.00	MI SCCELLANEOUS INCOME	B	-690	CLINIC	90.00	0 34.00
35.00			0		0.00	0 35.00
35.01			0		0.00	0 35.01
35.02			0		0.00	0 35.02
35.03			0		0.00	0 35.03
35.04			0		0.00	0 35.04
35.05			0		0.00	0 35.05
35.06			0		0.00	0 35.06
35.07			0		0.00	0 35.07
35.08	NON ALLOWABLE EXPENSES	A	-1,301,237	ADMINISTRATIVE & GENERAL	5.00	0 35.08
35.09	NON ALLOWABLE EXPENSES	A	-302	HOUSEKEEPING	9.00	0 35.09
36.00	NON ALLOWABLE EXPENSES	A	-687	DIETARY	10.00	0 36.00
36.01	NON ALLOWABLE EXPENSES	A	-571	PHARMACY	15.00	0 36.01
36.02	NON ALLOWABLE EXPENSES	A	-35	MEDICAL RECORDS & LIBRARY	16.00	0 36.02
36.03	NON ALLOWABLE EXPENSES	A	-8,522	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0 36.03
36.04	NON ALLOWABLE EXPENSES	A	-1,152	CLINICAL PASTORAL EDUCATION	23.00	0 36.04
36.05	NON ALLOWABLE EXPENSES	A	-1,829	ADULTS & PEDIATRICS	30.00	0 36.05
36.06	NON ALLOWABLE EXPENSES	A	-188	INTENSIVE CARE UNIT	31.00	0 36.06
36.07	NON ALLOWABLE EXPENSES	A	-126	SUBPROVIDER - IRF	41.00	0 36.07
36.09	NON ALLOWABLE EXPENSES	A	-985	OPERATING ROOM	50.00	0 36.09
36.10	NON ALLOWABLE EXPENSES	A	-9,038	RADIOLOGY-DIAGNOSTIC	54.00	0 36.10
36.11	NON ALLOWABLE EXPENSES	A	-35	RESPIRATORY THERAPY	65.00	0 36.11
36.13	NON ALLOWABLE EXPENSES	A	-98	PHYSICAL THERAPY	66.00	0 36.13
36.14	NON ALLOWABLE EXPENSES	A	-32	SPEECH PATHOLOGY	68.00	0 36.14
36.15	MARKETING OFFSET	A	-47,026	ADMINISTRATIVE & GENERAL	5.00	0 36.15
36.16			0		0.00	0 36.16
36.17	LOBBYING FEES	A	4,032	ADMINISTRATIVE & GENERAL	5.00	0 36.17
36.18	NON ALLOWABLE EXPENSES	A	-137	EMERGENCY	91.00	0 36.18
36.19	PA ASSESSMENT EXPENSE	A	-7,020,838	ADMINISTRATIVE & GENERAL	5.00	0 36.19
37.00	NON ALLOWABLE EXPENSES	A	-20	CARDIAC REHABILITATION	76.97	0 37.00
38.00	SELF INSURANCE EXPENSE	A	-2,422,559	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 38.00
39.00			0		0.00	0 39.00
40.00			0		0.00	0 40.00
41.00	EUREKA OVERALLOCATION	A	211,374	ADMINISTRATIVE & GENERAL	5.00	0 41.00
42.00	CONTRIBUTIONS	A	-17,170	ADMINISTRATIVE & GENERAL	5.00	0 42.00
43.00	INTEREST EXPENSE	A	-4,916,027	INTEREST EXPENSE	113.00	11 43.00
44.00	MOB/POB ADD-ON	A	409,485	OPERATION OF PLANT	7.00	0 44.00
44.01	MOB/POB ADD-ON	A	512,370	NEW CAP REL COSTS-BLDG & FIXT	1.00	9 44.01
44.02	MOB/POB ADD-ON	A	-13,302	ADMINISTRATIVE & GENERAL	5.00	0 44.02
44.03	MOB/POB ADD-ON	A	25,391	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9 44.03
44.04	ADJ BOOK TO MC DEPR	A	201,548	NEW CAP REL COSTS-BLDG & FIXT	1.00	9 44.04
44.05	ADJ BOOK TO MC DEPR	A	-63,355	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9 44.05
45.00			0		0.00	0 45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-28,073,185			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.

ADJUSTMENTS TO EXPENSES

Provider CCN: 140127

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

Worksheet A-8

Date/Time Prepared:
5/25/2016 12:55 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
	1.00	2.00	3.00	4.00	5.00

(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: 140127

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

Worksheet A-8-1

Date/Time Prepared:
5/25/2016 12:55 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	54.00	RADIOLOGY-DIAGNOSTIC	ADVANCED MRI	75,373	90,240	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	267,406	0	4.00
4.01	2.00	NEW CAP REL COSTS-MVBLE EQUI	HOME OFFICE	1,096,705	0	4.01
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2,035,737	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	5,963,361	14,544,049	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
5.00	0			9,438,582	14,634,289	5.00

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

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

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

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

6.00	C	0.00	ADVANCED MRI	42.80	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00	B	0.00	ADVOCATE HEALTH CARE	100.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 140127

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

Worksheet A-8-1

Date/Time Prepared:
5/25/2016 12:55 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	-14,867	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	267,406	9		4.00
4.01	1,096,705	9		4.01
4.02	2,035,737	0		4.02
4.03	-8,580,688	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
5.00	-5,195,707			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	MRI SERVICES		6.00
7.00			7.00
8.00			8.00
9.00	HOME OFFICE		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140127

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

Worksheet A-8-2

Date/Time Prepared:
5/25/2016 12:55 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	3,479	3,479	0	171,400	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	4,422,691	4,422,691	0	171,400	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	1,778,052	1,778,052	0	171,400	0	3.00
4.00	50.00	OPERATING ROOM	799,361	799,361	0	171,400	0	4.00
5.00	57.00	CT SCAN	12,200	12,200	0	171,400	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			7,015,783	7,015,783	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	57.00	CT SCAN	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	3,479		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	4,422,691		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,778,052		3.00
4.00	50.00	OPERATING ROOM	0	0	0	799,361		4.00
5.00	57.00	CT SCAN	0	0	0	12,200		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	7,015,783		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140127

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

Worksheet B Part I Date/Time Prepared: 5/25/2016 12:55 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	6,288,969	6,288,969			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	6,762,532		6,762,532		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	10,546,491	7,422	3,275	10,557,188	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	25,035,544	689,991	972,246	1,390,841	5.00
7.00 00700	OPERATION OF PLANT	5,439,902	1,567,026	193,538	240,836	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	343,831	92,318	52,216	61,188	8.00
9.00 00900	HOUSEKEEPING	1,850,857	43,041	13,526	220,119	9.00
10.00 01000	DIETARY	879,576	76,536	38,619	90,808	10.00
11.00 01100	CAFETERIA	438,208	41,211	0	91,721	11.00
13.00 01300	NURSING ADMINISTRATION	2,067,780	229,599	8,344	364,987	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	655,613	67,422	51,973	63,739	14.00
15.00 01500	PHARMACY	8,094,926	50,325	124,064	418,150	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,826,012	15,681	15,805	240,706	16.00
17.00 01700	SOCIAL SERVICE	1,390,919	0	0	211,296	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,734,211	0	0	270,358	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	-2,836	28,105	1,859	0	22.00
23.00 02300	CLINICAL PASTORAL EDUCATION	309,695	32,594	1,467	51,211	23.00
23.01 02301	EMS PROGRAM	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	13,164,270	1,040,409	712,857	1,956,143	30.00
31.00 03100	INTENSIVE CARE UNIT	4,126,035	306,291	407,863	662,571	31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	1,100,561	99,887	800	172,403	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	1,856,234	199,442	0	394,960	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,316,982	364,019	1,297,118	695,191	50.00
51.00 05100	RECOVERY ROOM	702,135	27,655	13,815	124,862	51.00
53.00 05300	ANESTHESIOLOGY	85,867	0	5,601	8,241	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,098,067	243,054	992,045	468,669	54.00
57.00 05700	CT SCAN	503,408	0	281,831	81,498	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	2,815,706	177,719	180,641	386,184	60.00
65.00 06500	RESPIRATORY THERAPY	931,132	65,362	39,853	164,722	65.00
66.00 06600	PHYSICAL THERAPY	1,404,049	183,173	55,553	236,489	66.00
67.00 06700	OCCUPATIONAL THERAPY	304,455	0	0	54,306	67.00
68.00 06800	SPEECH PATHOLOGY	243,230	0	397	43,227	68.00
69.00 06900	ELECTROCARDIOLOGY	1,864,190	130,255	1,111,511	312,435	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	155,367	24,362	7,988	14,950	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,114,400	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	9,746,155	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97 07697	CARDIAC REHABILITATION	377,832	31,609	10,432	66,126	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	645,425	29,798	1,447	109,941	90.00
90.01 09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	90.01
90.03 09002	PSYCH OUTPATIENT	0	0	0	0	90.03
90.04 09003	WOUND CARE CLINIC	999,996	30,239	955	89,218	90.04
91.00 09100	EMERGENCY	3,534,560	179,595	136,191	603,622	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040	OTHER OUTPATIENT SERVICES	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	136,752,286	6,074,140	6,733,830	10,361,718	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,064,598	108,256	11,294	73,869	190.00
190.01 19001	OTHER NONREIMBURSABLE	2,496,115	106,573	17,408	121,601	190.01
190.13 19007	EUREKA	0	0	0	0	190.13
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140127

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

Worksheet B
Part I
Date/Time Prepared:
5/25/2016 12:55 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
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)	140,312,999	6,288,969	6,762,532	10,557,188	140,312,999	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 140127		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part I Date/Time Prepared: 5/25/2016 12:55 pm	
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,088,622					5.00
7.00	00700	OPERATION OF PLANT	1,862,483	9,303,785				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	137,548	213,417	900,518			8.00
9.00	00900	HOUSEKEEPING	532,503	99,501	59,976	2,819,523		9.00
10.00	01000	DIETARY	271,700	176,934	1,981	74,652	1,610,806	10.00
11.00	01100	CAFETERIA	142,951	95,270	2,001	103,870	0	11.00
13.00	01300	NURSING ADMINISTRATION	668,452	530,779	0	6,831	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	209,930	155,864	0	71,401	0	14.00
15.00	01500	PHARMACY	2,174,386	116,340	0	29,219	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	525,159	36,250	0	13,004	0	16.00
17.00	01700	SOCIAL SERVICE	401,018	0	0	1,605	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	501,724	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	6,790	64,973	0	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	98,856	75,349	0	10,700	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,223,293	2,405,186	319,563	973,559	1,113,404	30.00
31.00	03100	INTENSIVE CARE UNIT	1,377,286	708,074	101,285	55,186	361,909	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	343,811	230,915	22,909	45,433	135,493	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	613,370	461,065	4,080	16,214	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,920,553	841,529	127,208	451,079	0	50.00
51.00	05100	RECOVERY ROOM	217,369	63,932	12,187	30,001	0	51.00
53.00	05300	ANESTHESIOLOGY	24,956	0	0	2,963	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,201,851	561,884	55,859	160,003	0	54.00
57.00	05700	CT SCAN	216,936	0	14,565	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	891,095	410,846	600	90,002	0	60.00
65.00	06500	RESPIRATORY THERAPY	300,616	151,101	0	13,334	0	65.00
66.00	06600	PHYSICAL THERAPY	470,361	423,454	12,701	82,635	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	89,794	0	153	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	71,797	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	855,589	301,119	10,551	33,334	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	50,726	56,320	1,898	6,626	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,531,533	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,439,365	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	470	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	121,641	73,074	699	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	196,881	68,885	3	22,182	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	280,427	69,906	4,409	27,984	0	90.04
91.00	09100	EMERGENCY	1,114,784	415,184	147,420	427,252	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,087,534	8,807,151	900,518	2,749,069	1,610,806	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	314,869	250,262	0	50,001	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	686,219	246,372	0	20,453	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	28,088,622	9,303,785	900,518	2,819,523	1,610,806	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part I Date/Time Prepared: 5/25/2016 12:55 pm
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	915,232					11.00
13.00	01300	27,047	3,903,819				13.00
14.00	01400	12,962	11,149	1,300,053			14.00
15.00	01500	31,759	7,652	16,871	11,063,692		15.00
16.00	01600	31,593	20,404	2,945	0	2,727,559	16.00
17.00	01700	18,517	109,454	47	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	31,172	0	4,515	0	0	22.00
23.00	02300	9,731	0	10,509	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	216,719	1,509,540	144,041	6,043	133,062	30.00
31.00	03100	75,624	559,729	53,533	2,288	33,914	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	20,075	161,484	7,292	16	15,976	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	42,192	310,143	24,231	0	23,137	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	75,216	460,040	111,767	50,939	394,617	50.00
51.00	05100	10,689	76,807	1,290	3,410	23,099	51.00
53.00	05300	1,545	9,911	549	57,155	53,466	53.00
54.00	05400	49,510	1,603	55,344	8,397	250,371	54.00
57.00	05700	6,883	0	3,909	34,850	272,355	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	51,898	4,227	66,852	538	308,069	60.00
65.00	06500	19,806	7,287	3,562	1,869	28,987	65.00
66.00	06600	21,032	73	14,603	0	30,695	66.00
67.00	06700	5,210	0	56	0	7,870	67.00
68.00	06800	3,537	0	245	0	3,565	68.00
69.00	06900	24,289	174,018	31,715	87,745	221,087	69.00
70.00	07000	1,456	0	83	0	5,927	70.00
71.00	07100	0	0	0	0	547	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	8,655,045	310,789	73.00
76.97	07697	7,573	6,340	6,516	0	5,081	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	10,944	13,044	13,325	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.03	09002	0	0	0	0	0	90.03
90.04	09003	9,067	11,222	5,061	6	59,387	90.04
91.00	09100	65,153	445,320	54,958	131,725	545,558	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
116.00	11600	0	0	0	0	0	116.00
118.00		881,199	3,899,447	633,819	9,040,026	2,727,559	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	17,572	0	623,344	0	0	190.00
190.01	19001	16,461	4,372	42,890	2,023,666	0	190.01
190.13	19007	0	0	0	0	0	190.13
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		915,232	3,903,819	1,300,053	11,063,692	2,727,559	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140127

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

Worksheet B
Part I
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Cost Center Description	INTERNS & RESIDENTS			CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
	SOCIAL SERVICE	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
		17.00	21.00			
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
17.00 01700 SOCIAL SERVICE	2,132,856					17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	2,506,293				21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0		134,578			22.00
23.00 02300 CLINICAL PASTORAL EDUCATION	0			600,112		23.00
23.01 02301 EMS PROGRAM	0				0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	1,148,290	2,506,293	134,578	293,949	0	30.00
31.00 03100 INTENSIVE CARE UNIT	501,718	0	0	117,311	0	31.00
40.00 04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	185,369	0	0	11,946	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	19,425	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	93,822	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	403	0	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	7,919	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 PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	13,320	0	0	0	0	90.00
90.01 09001 BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03 09002 PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04 09003 WOUND CARE CLINIC	0	0	0	0	0	90.04
91.00 09100 EMERGENCY	264,734	0	0	65,769	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	0	0	0	0	99.10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2,132,856	2,506,293	134,578	591,119	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 19001 OTHER NONREIMBURSABLE	0	0	0	8,993	0	190.01
190.13 19007 EUREKA	0	0	0	0	0	190.13
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140127

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

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Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS		CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
		SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
		17.00	21.00			
202.00 TOTAL (sum lines 118-201)	2,132,856	2,506,293	134,578	600,112	23.01	0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140127

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

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Part I
Date/Time Prepared:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMINISTRATIVE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPING				9.00
10.00	01000 DIETARY				10.00
11.00	01100 CAFETERIA				11.00
13.00	01300 NURSING ADMINISTRATION				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY				14.00
15.00	01500 PHARMACY				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY				16.00
17.00	01700 SOCIAL SERVICE				17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300 CLINICAL PASTORAL EDUCATION				23.00
23.01	02301 EMS PROGRAM				23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	32,001,199	-2,640,871	29,360,328	30.00
31.00	03100 INTENSIVE CARE UNIT	9,450,617	0	9,450,617	31.00
40.00	04000 SUBPROVIDER - IPF	0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	2,554,370	0	2,554,370	41.00
42.00	04200 SUBPROVIDER	0	0	0	42.00
43.00	04300 NURSERY	3,964,493	0	3,964,493	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	12,200,080	0	12,200,080	50.00
51.00	05100 RECOVERY ROOM	1,307,251	0	1,307,251	51.00
53.00	05300 ANESTHESIOLOGY	250,254	0	250,254	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,147,060	0	7,147,060	54.00
57.00	05700 CT SCAN	1,416,235	0	1,416,235	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	5,384,377	0	5,384,377	60.00
65.00	06500 RESPIRATORY THERAPY	1,727,631	0	1,727,631	65.00
66.00	06600 PHYSICAL THERAPY	2,934,818	0	2,934,818	66.00
67.00	06700 OCCUPATIONAL THERAPY	461,844	0	461,844	67.00
68.00	06800 SPEECH PATHOLOGY	365,998	0	365,998	68.00
69.00	06900 ELECTROCARDIOLOGY	5,165,757	0	5,165,757	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	325,703	0	325,703	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12,646,480	0	12,646,480	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	12,185,520	0	12,185,520	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,966,304	0	8,966,304	73.00
76.97	07697 CARDIAC REHABILITATION	706,923	0	706,923	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1,125,195	0	1,125,195	90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0	0	0	90.01
90.03	09002 PSYCH OUTPATIENT	0	0	0	90.03
90.04	09003 WOUND CARE CLINIC	1,587,877	0	1,587,877	90.04
91.00	09100 EMERGENCY	8,131,825	0	8,131,825	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICES	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF	0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	111.00
113.00	11300 INTEREST EXPENSE	0	0	0	113.00
116.00	11600 HOSPICE	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	132,007,811	-2,640,871	129,366,940	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,514,065	0	2,514,065	190.00
190.01	19001 OTHER NONREIMBURSABLE	5,791,123	0	5,791,123	190.01
190.13	19007 EUREKA	0	0	0	190.13
191.00	19100 RESEARCH	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140127

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

Worksheet B
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
202.00	TOTAL (sum lines 118-201)	140,312,999	-2,640,871	137,672,128	202.00

COST ALLOCATION STATISTICS

Provider CCN: 140127

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

Worksheet Non-CMS W
Date/Time Prepared:
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Cost Center Description		Statistics Code	Statistics Description		
		1.00		2.00	
	GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE	FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3	DOLLAR	VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	5	GROSS	SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-31	ACCUM.	COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE	FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	11	POUNDS OF	LAUNDRY	8.00
9.00	HOUSEKEEPING	12	HOURS OF	SERVICE	9.00
10.00	DIETARY	13	MEALS	SERVED	10.00
11.00	CAFETERIA	14	FTE'S		11.00
13.00	NURSING ADMINISTRATION	30	NURSING	FTE'S	13.00
14.00	CENTRAL SERVICES & SUPPLY	15	COSTED	REQUIS.	14.00
15.00	PHARMACY	16	COSTED	REQUISITIO	15.00
16.00	MEDICAL RECORDS & LIBRARY	19	TIME	SPENT	16.00
17.00	SOCIAL SERVICE	20	TIME	SPENT	17.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	23	ASSIGNED	TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	23	ASSIGNED	TIME	22.00
23.00	CLINICAL PASTORAL EDUCATION	24	ASSIGNED	TIME	23.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/25/2016 12:55 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,422	3,275	10,697	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	18,068	689,991	972,246	1,680,305	5.00
7.00 00700	OPERATION OF PLANT	3,667	1,567,026	193,538	1,764,231	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	19,119	92,318	52,216	163,653	8.00
9.00 00900	HOUSEKEEPING	2,286	43,041	13,526	58,853	9.00
10.00 01000	DIETARY	17,848	76,536	38,619	133,003	10.00
11.00 01100	CAFETERIA	0	41,211	0	41,211	11.00
13.00 01300	NURSING ADMINISTRATION	0	229,599	8,344	237,943	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	67,422	51,973	119,395	14.00
15.00 01500	PHARMACY	89,669	50,325	124,064	264,058	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	15,681	15,805	31,486	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	7,998	28,105	1,859	37,962	22.00
23.00 02300	CLINICAL PASTORAL EDUCATION	0	32,594	1,467	34,061	23.00
23.01 02301	EMS PROGRAM	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	121,338	1,040,409	712,857	1,874,604	30.00
31.00 03100	INTENSIVE CARE UNIT	52,569	306,291	407,863	766,723	31.00
40.00 04000	SUBPROVIDER - I PF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I RF	24,578	99,887	800	125,265	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	199,442	0	199,442	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	18,000	364,019	1,297,118	1,679,137	50.00
51.00 05100	RECOVERY ROOM	0	27,655	13,815	41,470	51.00
53.00 05300	ANESTHESIOLOGY	0	0	5,601	5,601	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	140,883	243,054	992,045	1,375,982	54.00
57.00 05700	CT SCAN	12,108	0	281,831	293,939	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	56,013	177,719	180,641	414,373	60.00
65.00 06500	RESPIRATORY THERAPY	0	65,362	39,853	105,215	65.00
66.00 06600	PHYSICAL THERAPY	117,451	183,173	55,553	356,177	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	397	397	68.00
69.00 06900	ELECTROCARDIOLOGY	0	130,255	1,111,511	1,241,766	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	24,362	7,988	32,350	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97 07697	CARDIAC REHABILITATION	0	31,609	10,432	42,041	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	29,798	1,447	31,245	90.00
90.01 09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	90.01
90.03 09002	PSYCH OUTPATIENT	0	0	0	0	90.03
90.04 09003	WOUND CARE CLINIC	0	30,239	955	31,194	90.04
91.00 09100	EMERGENCY	0	179,595	136,191	315,786	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040	OTHER OUTPATIENT SERVICES	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	701,595	6,074,140	6,733,830	13,509,565	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	108,256	11,294	119,550	190.00
190.01 19001	OTHER NONREIMBURSABLE	6,396	106,573	17,408	130,377	190.01
190.13 19007	EUREKA	0	0	0	0	190.13
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
200.00	Cross Foot Adjustments				0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140127

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

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	707,991	6,288,969	6,762,532	13,759,492	10,697	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/25/2016 12:55 pm		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,681,717				5.00
7.00	00700	OPERATION OF PLANT	111,508	1,875,983			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,235	43,033	214,983		8.00
9.00	00900	HOUSEKEEPING	31,881	20,063	14,318	125,338	9.00
10.00	01000	DIETARY	16,267	35,676	473	3,319	188,830
11.00	01100	CAFETERIA	8,559	19,210	478	4,617	0
13.00	01300	NURSING ADMINISTRATION	40,021	107,024	0	304	0
14.00	01400	CENTRAL SERVICES & SUPPLY	12,569	31,428	0	3,174	0
15.00	01500	PHARMACY	130,182	23,458	0	1,299	0
16.00	01600	MEDICAL RECORDS & LIBRARY	31,442	7,309	0	578	0
17.00	01700	SOCIAL SERVICE	24,009	0	0	71	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	30,038	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	407	13,101	0	0	0
23.00	02300	CLINICAL PASTORAL EDUCATION	5,919	15,193	0	476	0
23.01	02301	EMS PROGRAM	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	252,885	484,973	76,291	43,276	130,522
31.00	03100	INTENSIVE CARE UNIT	82,459	142,774	24,180	2,453	42,425
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0
41.00	04100	SUBPROVIDER - I RF	20,584	46,561	5,469	2,020	15,883
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	36,723	92,967	974	721	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	114,985	169,683	30,369	20,052	0
51.00	05100	RECOVERY ROOM	13,014	12,891	2,909	1,334	0
53.00	05300	ANESTHESIOLOGY	1,494	0	0	132	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,955	113,296	13,335	7,113	0
57.00	05700	CT SCAN	12,988	0	3,477	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	53,350	82,842	143	4,001	0
65.00	06500	RESPIRATORY THERAPY	17,998	30,468	0	593	0
66.00	06600	PHYSICAL THERAPY	28,161	85,384	3,032	3,673	0
67.00	06700	OCCUPATIONAL THERAPY	5,376	0	36	0	0
68.00	06800	SPEECH PATHOLOGY	4,299	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	51,225	60,717	2,519	1,482	0
70.00	07000	ELECTROENCEPHALOGRAPHY	3,037	11,356	453	295	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	151,564	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	146,046	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	112	0	0
76.97	07697	CARDIAC REHABILITATION	7,283	14,734	167	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	11,787	13,890	1	986	0
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0
90.04	09003	WOUND CARE CLINIC	16,789	14,096	1,053	1,244	0
91.00	09100	EMERGENCY	66,743	83,716	35,194	18,993	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,621,782	1,775,843	214,983	122,206	188,830
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,851	50,462	0	2,223	0
190.01	19001	OTHER NONREIMBURSABLE	41,084	49,678	0	909	0
190.13	19007	EUREKA	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,681,717	1,875,983	214,983	125,338	188,830

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140127		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 5/25/2016 12:55 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	74,168					11.00
13.00	01300	2,192	387,854				13.00
14.00	01400	1,050	1,108	168,789			14.00
15.00	01500	2,574	760	2,190	424,945		15.00
16.00	01600	2,560	2,027	382	0	76,028	16.00
17.00	01700	1,501	10,874	6	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	2,526	0	586	0	0	22.00
23.00	02300	789	0	1,364	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	17,562	149,978	18,701	232	3,709	30.00
31.00	03100	6,128	55,610	6,950	88	945	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	1,627	16,044	947	1	445	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	3,419	30,813	3,146	0	645	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,095	45,706	14,511	1,957	11,000	50.00
51.00	05100	866	7,631	167	131	644	51.00
53.00	05300	125	985	71	2,195	1,490	53.00
54.00	05400	4,012	159	7,185	323	6,979	54.00
57.00	05700	558	0	507	1,339	7,592	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	4,206	420	8,680	21	8,587	60.00
65.00	06500	1,605	724	462	72	808	65.00
66.00	06600	1,704	7	1,896	0	856	66.00
67.00	06700	422	0	7	0	219	67.00
68.00	06800	287	0	32	0	99	68.00
69.00	06900	1,968	17,289	4,118	3,370	6,163	69.00
70.00	07000	118	0	11	0	165	70.00
71.00	07100	0	0	0	0	15	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	332,430	8,663	73.00
76.97	07697	614	630	846	0	142	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	887	1,296	1,730	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.03	09002	0	0	0	0	0	90.03
90.04	09003	735	1,115	657	0	1,655	90.04
91.00	09100	5,280	44,244	7,135	5,059	15,207	91.00
92.00	09200						92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
118.00		71,410	387,420	82,287	347,218	76,028	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,424	0	80,934	0	0	190.00
190.01	19001	1,334	434	5,568	77,727	0	190.01
190.13	19007	0	0	0	0	0	190.13
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		74,168	387,854	168,789	424,945	76,028	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/25/2016 12:55 pm		
Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS		CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
		SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
		17.00	21.00			22.00
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	36,675			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	30,312		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	53,455	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	0	0	57,854	23.00
23.01	02301	EMS PROGRAM	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,746			30.00
31.00	03100	INTENSIVE CARE UNIT	8,627			31.00
40.00	04000	SUBPROVIDER - IPF	0			40.00
41.00	04100	SUBPROVIDER - IRF	3,187			41.00
42.00	04200	SUBPROVIDER	0			42.00
43.00	04300	NURSERY	334			43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0			50.00
51.00	05100	RECOVERY ROOM	0			51.00
53.00	05300	ANESTHESIOLOGY	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0			54.00
57.00	05700	CT SCAN	0			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0			59.00
60.00	06000	LABORATORY	0			60.00
65.00	06500	RESPIRATORY THERAPY	0			65.00
66.00	06600	PHYSICAL THERAPY	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0			67.00
68.00	06800	SPEECH PATHOLOGY	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0			73.00
76.97	07697	CARDIAC REHABILITATION	0			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	229			90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0			90.01
90.03	09002	PSYCH OUTPATIENT	0			90.03
90.04	09003	WOUND CARE CLINIC	0			90.04
91.00	09100	EMERGENCY	4,552			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0			93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0			99.10
101.00	10100	HOME HEALTH AGENCY	0			101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0			110.00
111.00	11100	ISLET ACQUISITION	0			111.00
113.00	11300	INTEREST EXPENSE	0			113.00
116.00	11600	HOSPICE	0			116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,675	0	0	0
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
190.01	19001	OTHER NONREIMBURSABLE	0			190.01
190.13	19007	EUREKA	0			190.13
191.00	19100	RESEARCH	0			191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0			192.00
200.00		Cross Foot Adjustments	0	30,312	53,455	57,854
201.00		Negative Cost Centers	0	0	1,127	0

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140127		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 5/25/2016 12:55 pm	
Cost Center Description		INTERNS & RESIDENTS			CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
		SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS			
202.00	TOTAL (sum lines 118-201)	36,675	30,312	54,582	57,854	23.01	0202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/25/2016 12:55 pm
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
23.01	02301				23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	3,074,448	0	3,074,448	30.00
31.00	03100	1,140,034	0	1,140,034	31.00
40.00	04000	0	0	0	40.00
41.00	04100	238,208	0	238,208	41.00
42.00	04200	0	0	0	42.00
43.00	04300	369,585	0	369,585	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	2,094,201	0	2,094,201	50.00
51.00	05100	81,184	0	81,184	51.00
53.00	05300	12,101	0	12,101	53.00
54.00	05400	1,600,815	0	1,600,815	54.00
57.00	05700	320,483	0	320,483	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	577,015	0	577,015	60.00
65.00	06500	158,112	0	158,112	65.00
66.00	06600	481,130	0	481,130	66.00
67.00	06700	6,115	0	6,115	67.00
68.00	06800	5,158	0	5,158	68.00
69.00	06900	1,390,934	0	1,390,934	69.00
70.00	07000	47,800	0	47,800	70.00
71.00	07100	151,579	0	151,579	71.00
72.00	07200	146,046	0	146,046	72.00
73.00	07300	341,205	0	341,205	73.00
76.97	07697	66,524	0	66,524	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	62,163	0	62,163	90.00
90.01	09001	0	0	0	90.01
90.03	09002	0	0	0	90.03
90.04	09003	68,629	0	68,629	90.04
91.00	09100	602,522	0	602,522	91.00
92.00	09200	0	0	0	92.00
93.00	04040	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	0	0	0	99.10
101.00	10100	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	0	0	0	109.00
110.00	11000	0	0	0	110.00
111.00	11100	0	0	0	111.00
113.00	11300	0	0	0	113.00
116.00	11600	0	0	0	116.00
118.00		13,035,991	0	13,035,991	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	273,519	0	273,519	190.00
190.01	19001	307,234	0	307,234	190.01
190.13	19007	0	0	0	190.13
191.00	19100	0	0	0	191.00
192.00	19200	0	0	0	192.00
200.00		141,621	0	141,621	200.00
201.00		1,127	0	1,127	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140127

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

Worksheet B
Part II
Date/Time Prepared:
5/25/2016 12:55 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
202.00	TOTAL (sum lines 118-201)	13,759,492	0	13,759,492	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140127

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

Worksheet B-1

Date/Time Prepared:
5/25/2016 12:55 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	683,820				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		5,761,583			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	807	2,790	54,948,916		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	75,025	828,340	7,239,176	-28,088,622	5.00
7.00 00700	OPERATION OF PLANT	170,388	164,892	1,253,524	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	10,038	44,487	318,479	0	8.00
9.00 00900	HOUSEKEEPING	4,680	11,524	1,145,693	0	9.00
10.00 01000	DIETARY	8,322	32,903	472,644	0	10.00
11.00 01100	CAFETERIA	4,481	0	477,396	0	11.00
13.00 01300	NURSING ADMINISTRATION	24,965	7,109	1,899,716	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	7,331	44,280	331,756	0	14.00
15.00 01500	PHARMACY	5,472	105,701	2,176,423	5,472	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,705	13,466	1,252,850	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	1,099,771	0	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,407,186	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	3,056	1,584	0	0	22.00
23.00 02300	CLINICAL PASTORAL EDUCATION	3,544	1,250	266,546	0	23.00
23.01 02301	EMS PROGRAM	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	113,127	607,344	10,181,440	0	30.00
31.00 03100	INTENSIVE CARE UNIT	33,304	347,494	3,448,609	0	31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	10,861	682	897,338	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	21,686	0	2,055,724	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	39,581	1,105,125	3,618,391	0	50.00
51.00 05100	RECOVERY ROOM	3,007	11,770	649,891	0	51.00
53.00 05300	ANESTHESIOLOGY	0	4,772	42,893	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	26,428	845,209	2,439,369	0	54.00
57.00 05700	CT SCAN	0	240,116	424,186	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	19,324	153,904	2,010,043	0	60.00
65.00 06500	RESPIRATORY THERAPY	7,107	33,954	857,360	0	65.00
66.00 06600	PHYSICAL THERAPY	19,917	47,330	1,230,897	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	282,655	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	338	224,990	0	68.00
69.00 06900	ELECTROCARDIOLOGY	14,163	946,992	1,626,190	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	2,649	6,806	77,815	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97 07697	CARDIAC REHABILITATION	3,437	8,888	344,176	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	3,240	1,233	572,233	0	90.00
90.01 09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	90.01
90.03 09002	PSYCH OUTPATIENT	0	0	0	0	90.03
90.04 09003	WOUND CARE CLINIC	3,288	814	464,371	0	90.04
91.00 09100	EMERGENCY	19,528	116,033	3,141,784	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040	OTHER OUTPATIENT SERVICES	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	660,461	5,737,130	53,931,515	-28,088,622	108,224,663
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,771	9,622	384,481	0	190.00
190.01 19001	OTHER NONREIMBURSABLE	11,588	14,831	632,920	0	190.01
190.13 19007	EUREKA	0	0	0	0	190.13
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140127

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

Worksheet B-1

Date/Time Prepared:
5/25/2016 12:55 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
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)	6,288,969	6,762,532	10,557,188		28,088,622	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9.196819	1.173728	0.192127		0.250290	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			10,697		1,681,717	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000195		0.014985	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140127

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

Worksheet B-1

Date/Time Prepared:
5/25/2016 12:55 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	437,600				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,038	1,008,007			8.00
9.00	00900	HOUSEKEEPING	4,680	67,135	68,513		9.00
10.00	01000	DIETARY	8,322	2,217	1,814	101,088	10.00
11.00	01100	CAFETERIA	4,481	2,240	2,524	0	71,670
13.00	01300	NURSING ADMINISTRATION	24,965	0	166	0	2,118
14.00	01400	CENTRAL SERVICES & SUPPLY	7,331	0	1,735	0	1,015
15.00	01500	PHARMACY	5,472	0	710	0	2,487
16.00	01600	MEDICAL RECORDS & LIBRARY	1,705	0	316	0	2,474
17.00	01700	SOCIAL SERVICE	0	0	39	0	1,450
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	3,056	0	0	0	2,441
23.00	02300	CLINICAL PASTORAL EDUCATION	3,544	0	260	0	762
23.01	02301	EMS PROGRAM	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	113,127	357,709	23,657	69,873	16,971
31.00	03100	INTENSIVE CARE UNIT	33,304	113,375	1,341	22,712	5,922
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	10,861	25,644	1,104	8,503	1,572
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	21,686	4,567	394	0	3,304
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	39,581	142,392	10,961	0	5,890
51.00	05100	RECOVERY ROOM	3,007	13,642	729	0	837
53.00	05300	ANESTHESIOLOGY	0	0	72	0	121
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,428	62,527	3,888	0	3,877
57.00	05700	CT SCAN	0	16,303	0	0	539
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	19,324	672	2,187	0	4,064
65.00	06500	RESPIRATORY THERAPY	7,107	0	324	0	1,551
66.00	06600	PHYSICAL THERAPY	19,917	14,217	2,008	0	1,647
67.00	06700	OCCUPATIONAL THERAPY	0	171	0	0	408
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	277
69.00	06900	ELECTROCARDIOLOGY	14,163	11,810	810	0	1,902
70.00	07000	ELECTROENCEPHALOGRAPHY	2,649	2,124	161	0	114
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	526	0	0	0
76.97	07697	CARDIAC REHABILITATION	3,437	782	0	0	593
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,240	3	539	0	857
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0
90.04	09003	WOUND CARE CLINIC	3,288	4,935	680	0	710
91.00	09100	EMERGENCY	19,528	165,016	10,382	0	5,102
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	414,241	1,008,007	66,801	101,088	69,005
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,771	0	1,215	0	1,376
190.01	19001	OTHER NONREIMBURSABLE	11,588	0	497	0	1,289
190.13	19007	EUREKA	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140127

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

Worksheet B-1

Date/Time Prepared:
5/25/2016 12:55 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	9,303,785	900,518	2,819,523	1,610,806	915,232	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	21.260935	0.893365	41.153110	15.934691	12.770085	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,875,983	214,983	125,338	188,830	74,168	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	4.286981	0.213275	1.829405	1.867976	1.034854	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140127

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

Worksheet B-1

Date/Time Prepared:
5/25/2016 12:55 pm

Cost Center Description		NURSING ADMINISTRATION (NURSING FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUISITO)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	53,571					13.00
14.00	01400	153	1,084,309				14.00
15.00	01500	105	14,071	7,469,363			15.00
16.00	01600	280	2,456	0	4,239,638		16.00
17.00	01700	1,502	39	0	0	3,843	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	3,766	0	0	0	22.00
23.00	02300	0	8,765	0	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	20,715	120,137	4,080	206,827	2,069	30.00
31.00	03100	7,681	44,649	1,545	52,715	904	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	2,216	6,082	11	24,832	334	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	4,256	20,210	0	35,963	35	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,313	93,219	34,390	613,381	0	50.00
51.00	05100	1,054	1,076	2,302	35,905	0	51.00
53.00	05300	136	458	38,587	83,106	0	53.00
54.00	05400	22	46,160	5,669	389,169	0	54.00
57.00	05700	0	3,260	23,528	423,341	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	58	55,758	363	478,853	0	60.00
65.00	06500	100	2,971	1,262	45,056	0	65.00
66.00	06600	1	12,180	0	47,712	0	66.00
67.00	06700	0	47	0	12,233	0	67.00
68.00	06800	0	204	0	5,542	0	68.00
69.00	06900	2,388	26,452	59,239	343,652	0	69.00
70.00	07000	0	69	0	9,213	0	70.00
71.00	07100	0	0	0	851	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	5,843,227	483,081	0	73.00
76.97	07697	87	5,435	0	7,897	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	179	11,114	0	0	24	90.00
90.01	09001	0	0	0	0	0	90.01
90.03	09002	0	0	0	0	0	90.03
90.04	09003	154	4,221	4	92,309	0	90.04
91.00	09100	6,111	45,838	88,931	848,000	477	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
116.00	11600	0	0	0	0	0	116.00
118.00		53,511	528,637	6,103,138	4,239,638	3,843	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	519,900	0	0	0	190.00
190.01	19001	60	35,772	1,366,225	0	0	190.01
190.13	19007	0	0	0	0	0	190.13
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140127

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

Worksheet B-1

Date/Time Prepared:
5/25/2016 12:55 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUISITION)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		(NURSING FTE'S)	(COSTED REQUIS.)		(TIME SPENT)	(TIME SPENT)	
202.00	Cost to be allocated (per Wkst. B, Part I)	3,903,819	1,300,053	11,063,692	2,727,559	2,132,856	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	72.871871	1.198969	1.481210	0.643347	554.997658	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	387,854	168,789	424,945	76,028	36,675	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	7.239999	0.155665	0.056892	0.017933	9.543326	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140127

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

Worksheet B-1

Date/Time Prepared:
5/25/2016 12:55 pm

Cost Center Description	INTERNS & RESIDENTS		CLINICAL PASTORAL EDUCATION (ASSIGNED TIME)	EMS PROGRAM (ASSIGNED TIME)	
	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
	21.00	22.00			
GENERAL SERVICE COST CENTERS					
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500 ADMINISTRATIVE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9.00 00900 HOUSEKEEPING					9.00
10.00 01000 DIETARY					10.00
11.00 01100 CAFETERIA					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15.00 01500 PHARMACY					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00
17.00 01700 SOCIAL SERVICE					17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	100				21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		100			22.00
23.00 02300 CLINICAL PASTORAL EDUCATION			4,471		23.00
23.01 02301 EMS PROGRAM				0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS	100	100	2,190	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	874	0	31.00
40.00 04000 SUBPROVIDER - IPF	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	89	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	42.00
43.00 04300 NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0	699	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	3	0	54.00
57.00 05700 CT SCAN	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	59	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	0	0	0	90.00
90.01 09001 BASIC DIAGNOSTIC TESTING	0	0	0	0	90.01
90.03 09002 PSYCH OUTPATIENT	0	0	0	0	90.03
90.04 09003 WOUND CARE CLINIC	0	0	0	0	90.04
91.00 09100 EMERGENCY	0	0	490	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICES	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
99.10 09910 CORF	0	0	0	0	99.10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE	0	0	0	0	113.00
116.00 11600 HOSPICE	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	100	100	4,404	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01 19001 OTHER NONREIMBURSABLE	0	0	67	0	190.01
190.13 19007 EUREKA	0	0	0	0	190.13
191.00 19100 RESEARCH	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140127

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	INTERNS & RESIDENTS		CLINICAL PASTORAL EDUCATION (ASSIGNED TIME)	EMS PROGRAM (ASSIGNED TIME)		
	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
	21.00	22.00				
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)	2,506,293	134,578	600,112	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	25,062.930000	1,345.780000	134.223216	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	30,312	54,582	57,854	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	303.120000	534.550000	12.939834	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140127		Period: From 01/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 5/25/2016 12:55 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		29,360,328	0	29,360,328	30.00	
31.00	03100 INTENSIVE CARE UNIT		9,450,617	0	9,450,617	31.00	
40.00	04000 SUBPROVIDER - I/PF		0	0	0	40.00	
41.00	04100 SUBPROVIDER - I/RF		2,554,370	0	2,554,370	41.00	
42.00	04200 SUBPROVIDER		0	0	0	42.00	
43.00	04300 NURSERY		3,964,493	0	3,964,493	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		12,200,080	0	12,200,080	50.00	
51.00	05100 RECOVERY ROOM		1,307,251	0	1,307,251	51.00	
53.00	05300 ANESTHESIOLOGY		250,254	0	250,254	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,147,060	0	7,147,060	54.00	
57.00	05700 CT SCAN		1,416,235	0	1,416,235	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00	
60.00	06000 LABORATORY		5,384,377	0	5,384,377	60.00	
65.00	06500 RESPIRATORY THERAPY	0	1,727,631	0	1,727,631	65.00	
66.00	06600 PHYSICAL THERAPY	0	2,934,818	0	2,934,818	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	461,844	0	461,844	67.00	
68.00	06800 SPEECH PATHOLOGY	0	365,998	0	365,998	68.00	
69.00	06900 ELECTROCARDIOLOGY		5,165,757	0	5,165,757	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY		325,703	0	325,703	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		12,646,480	0	12,646,480	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		12,185,520	0	12,185,520	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		8,966,304	0	8,966,304	73.00	
76.97	07697 CARDIAC REHABILITATION		706,923	0	706,923	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		1,125,195	0	1,125,195	90.00	
90.01	09001 BASIC DIAGNOSTIC TESTING		0	0	0	90.01	
90.03	09002 PSYCH OUTPATIENT		0	0	0	90.03	
90.04	09003 WOUND CARE CLINIC		1,587,877	0	1,587,877	90.04	
91.00	09100 EMERGENCY		8,131,825	0	8,131,825	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		3,361,908	0	3,361,908	92.00	
93.00	04040 OTHER OUTPATIENT SERVICES		0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	99.10	
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	109.00	
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	110.00	
111.00	11100 ISLET ACQUISITION	0	0	0	0	111.00	
113.00	11300 INTEREST EXPENSE		0	0	0	113.00	
116.00	11600 HOSPICE	0	0	0	0	116.00	
200.00	Subtotal (see instructions)		132,728,848	0	132,728,848	200.00	
201.00	Less Observation Beds		3,361,908	0	3,361,908	201.00	
202.00	Total (see instructions)		129,366,940	0	129,366,940	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140127		Period: From 01/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 5/25/2016 12:55 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,195,354		42,195,354			30.00
31.00	03100	INTENSIVE CARE UNIT	13,545,616		13,545,616			31.00
40.00	04000	SUBPROVIDER - I PF	0		0			40.00
41.00	04100	SUBPROVIDER - I RF	3,025,109		3,025,109			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	4,617,473		4,617,473			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,940,255	23,162,821	44,103,076	0.276627	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,522,065	2,066,954	3,589,019	0.364236	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	5,000,933	4,458,063	9,458,996	0.026457	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,736,048	30,062,341	38,798,389	0.184210	0.000000	54.00
57.00	05700	CT SCAN	11,209,299	31,598,036	42,807,335	0.033084	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	23,528,564	27,951,107	51,479,671	0.104592	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,171,511	782,609	4,954,120	0.348726	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,557,540	2,624,787	5,182,327	0.566313	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,662,060	280,921	1,942,981	0.237699	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	647,128	172,375	819,503	0.446610	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	11,874,967	17,000,783	28,875,750	0.178896	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	223,135	741,068	964,203	0.337795	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,536,967	4,617,472	11,154,439	1.133762	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,119,665	8,292,890	27,412,555	0.444523	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,755,877	24,167,044	68,922,921	0.130092	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	22,826	624,652	647,478	1.091810	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,219,839	1,219,839	0.922413	0.000000	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0.000000	0.000000	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0.000000	0.000000	90.03
90.04	09003	WOUND CARE CLINIC	325,033	7,235,122	7,560,155	0.210032	0.000000	90.04
91.00	09100	EMERGENCY	7,364,723	25,900,942	33,265,665	0.244451	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	832,120	3,788,399	4,620,519	0.727604	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	234,414,268	216,748,225	451,162,493			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	234,414,268	216,748,225	451,162,493			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/25/2016 12:55 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
INPATIENT ROUTINE SERVICE COST CENTERS		11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.276627		50.00
51.00	05100 RECOVERY ROOM	0.364236		51.00
53.00	05300 ANESTHESIOLOGY	0.026457		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.184210		54.00
57.00	05700 CT SCAN	0.033084		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.104592		60.00
65.00	06500 RESPIRATORY THERAPY	0.348726		65.00
66.00	06600 PHYSICAL THERAPY	0.566313		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.237699		67.00
68.00	06800 SPEECH PATHOLOGY	0.446610		68.00
69.00	06900 ELECTROCARDIOLOGY	0.178896		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.337795		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.133762		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.444523		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.130092		73.00
76.97	07697 CARDIAC REHABILITATION	1.091810		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.922413		90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0.000000		90.01
90.03	09002 PSYCH OUTPATIENT	0.000000		90.03
90.04	09003 WOUND CARE CLINIC	0.210032		90.04
91.00	09100 EMERGENCY	0.244451		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.727604		92.00
93.00	04040 OTHER OUTPATIENT SERVICES	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF			99.10
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140127		Period: From 01/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 5/25/2016 12:55 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		29,360,328		29,360,328	0	29,360,328
31.00	03100 INTENSIVE CARE UNIT		9,450,617		9,450,617	0	9,450,617
40.00	04000 SUBPROVIDER - I/PF		0		0	0	0
41.00	04100 SUBPROVIDER - I/RF		2,554,370		2,554,370	0	2,554,370
42.00	04200 SUBPROVIDER		0		0	0	0
43.00	04300 NURSERY		3,964,493		3,964,493	0	3,964,493
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		12,200,080		12,200,080	0	12,200,080
51.00	05100 RECOVERY ROOM		1,307,251		1,307,251	0	1,307,251
53.00	05300 ANESTHESIOLOGY		250,254		250,254	0	250,254
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,147,060		7,147,060	0	7,147,060
57.00	05700 CT SCAN		1,416,235		1,416,235	0	1,416,235
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0	0	0
59.00	05900 CARDIAC CATHETERIZATION		0		0	0	0
60.00	06000 LABORATORY		5,384,377		5,384,377	0	5,384,377
65.00	06500 RESPIRATORY THERAPY	0	1,727,631		1,727,631	0	1,727,631
66.00	06600 PHYSICAL THERAPY	0	2,934,818		2,934,818	0	2,934,818
67.00	06700 OCCUPATIONAL THERAPY	0	461,844		461,844	0	461,844
68.00	06800 SPEECH PATHOLOGY	0	365,998		365,998	0	365,998
69.00	06900 ELECTROCARDIOLOGY		5,165,757		5,165,757	0	5,165,757
70.00	07000 ELECTROENCEPHALOGRAPHY		325,703		325,703	0	325,703
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		12,646,480		12,646,480	0	12,646,480
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		12,185,520		12,185,520	0	12,185,520
73.00	07300 DRUGS CHARGED TO PATIENTS		8,966,304		8,966,304	0	8,966,304
76.97	07697 CARDIAC REHABILITATION		706,923		706,923	0	706,923
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		1,125,195		1,125,195	0	1,125,195
90.01	09001 BASIC DIAGNOSTIC TESTING		0		0	0	0
90.03	09002 PSYCH OUTPATIENT		0		0	0	0
90.04	09003 WOUND CARE CLINIC		1,587,877		1,587,877	0	1,587,877
91.00	09100 EMERGENCY		8,131,825		8,131,825	0	8,131,825
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		3,361,908		3,361,908	0	3,361,908
93.00	04040 OTHER OUTPATIENT SERVICES		0		0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF		0		0		0
101.00	10100 HOME HEALTH AGENCY		0		0		0
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION		0		0		0
110.00	11000 INTESTINAL ACQUISITION		0		0		0
111.00	11100 ISLET ACQUISITION		0		0		0
113.00	11300 INTEREST EXPENSE		0		0		0
116.00	11600 HOSPICE		0		0		0
200.00	Subtotal (see instructions)		132,728,848	0	132,728,848	0	132,728,848
201.00	Less Observation Beds		3,361,908		3,361,908		3,361,908
202.00	Total (see instructions)		129,366,940	0	129,366,940	0	129,366,940

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140127		Period: From 01/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 5/25/2016 12:55 pm	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,195,354		42,195,354			30.00
31.00	03100	INTENSIVE CARE UNIT	13,545,616		13,545,616			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	3,025,109		3,025,109			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	4,617,473		4,617,473			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,940,255	23,162,821	44,103,076	0.276627	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,522,065	2,066,954	3,589,019	0.364236	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	5,000,933	4,458,063	9,458,996	0.026457	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,736,048	30,062,341	38,798,389	0.184210	0.000000	54.00
57.00	05700	CT SCAN	11,209,299	31,598,036	42,807,335	0.033084	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	23,528,564	27,951,107	51,479,671	0.104592	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,171,511	782,609	4,954,120	0.348726	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,557,540	2,624,787	5,182,327	0.566313	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,662,060	280,921	1,942,981	0.237699	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	647,128	172,375	819,503	0.446610	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	11,874,967	17,000,783	28,875,750	0.178896	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	223,135	741,068	964,203	0.337795	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,536,967	4,617,472	11,154,439	1.133762	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,119,665	8,292,890	27,412,555	0.444523	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,755,877	24,167,044	68,922,921	0.130092	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	22,826	624,652	647,478	1.091810	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,219,839	1,219,839	0.922413	0.000000	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0.000000	0.000000	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0.000000	0.000000	90.03
90.04	09003	WOUND CARE CLINIC	325,033	7,235,122	7,560,155	0.210032	0.000000	90.04
91.00	09100	EMERGENCY	7,364,723	25,900,942	33,265,665	0.244451	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	832,120	3,788,399	4,620,519	0.727604	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	234,414,268	216,748,225	451,162,493			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	234,414,268	216,748,225	451,162,493			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/25/2016 12:55 pm
Cost Center Description		PPS Inpatient Ratio 11.00	Title XIX	Hospital
				Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0.000000		90.01
90.03	09002 PSYCH OUTPATIENT	0.000000		90.03
90.04	09003 WOUND CARE CLINIC	0.000000		90.04
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040 OTHER OUTPATIENT SERVICES	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF			99.10
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
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: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part I Date/Time Prepared: 5/25/2016 12:55 pm
		Title XVIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,074,448	0	3,074,448	24,130	127.41	30.00
31.00	INTENSIVE CARE UNIT	1,140,034		1,140,034	7,780	146.53	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	238,208	0	238,208	2,923	81.49	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	369,585		369,585	4,228	87.41	43.00
200.00	Total (Lines 30-199)	4,822,275		4,822,275	39,061		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	7,061	899,642				
31.00	INTENSIVE CARE UNIT	2,929	429,186				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	1,762	143,585				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	11,752	1,472,413				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 5/25/2016 12:55 pm
		Title XVIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,094,201	44,103,076	0.047484	8,221,572	390,393	50.00
51.00	05100	RECOVERY ROOM	81,184	3,589,019	0.022620	639,593	14,468	51.00
53.00	05300	ANESTHESIOLOGY	12,101	9,458,996	0.001279	1,759,764	2,251	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,600,815	38,798,389	0.041260	3,686,304	152,097	54.00
57.00	05700	CT SCAN	320,483	42,807,335	0.007487	4,648,485	34,803	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	577,015	51,479,671	0.011209	9,299,730	104,241	60.00
65.00	06500	RESPIRATORY THERAPY	158,112	4,954,120	0.031915	1,766,622	56,382	65.00
66.00	06600	PHYSICAL THERAPY	481,130	5,182,327	0.092841	756,619	70,245	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,115	1,942,981	0.003147	310,467	977	67.00
68.00	06800	SPEECH PATHOLOGY	5,158	819,503	0.006294	93,465	588	68.00
69.00	06900	ELECTROCARDIOLOGY	1,390,934	28,875,750	0.048170	4,812,682	231,827	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	47,800	964,203	0.049575	82,096	4,070	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	151,579	11,154,439	0.013589	2,597,985	35,304	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	146,046	27,412,555	0.005328	8,007,636	42,665	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	341,205	68,922,921	0.004951	15,829,053	78,370	73.00
76.97	07697	CARDIAC REHABILITATION	66,524	647,478	0.102743	8,720	896	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	62,163	1,219,839	0.050960	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0.000000	0	0	90.03
90.04	09003	WOUND CARE CLINIC	68,629	7,560,155	0.009078	146,249	1,328	90.04
91.00	09100	EMERGENCY	602,522	33,265,665	0.018112	2,809,699	50,889	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	352,039	4,620,519	0.076190	379,322	28,901	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	8,565,755	387,778,941		65,856,063	1,300,695	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part III Date/Time Prepared: 5/25/2016 12:55 pm
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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	293,949	0	0	293,949	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	117,311	0	0	117,311	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	11,946	0	0	11,946	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30-199)	0	423,206	0	0	423,206	200.00	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School		
			6.00	7.00	8.00	9.00	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	24,130	12.18	7,061	86,003	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	7,780	15.08	2,929	44,169	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	2,923	4.09	1,762	7,207	0	41.00	
42.00	04200	SUBPROVIDER	0	0.00	0	0	0	42.00	
43.00	04300	NURSERY	4,228	0.00	0	0	0	43.00	
200.00		Total (lines 30-199)	39,061		11,752	137,379	0	200.00	
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost					
			12.00	13.00					
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0	0					31.00
40.00	04000	SUBPROVIDER - IPF	0	0					40.00
41.00	04100	SUBPROVIDER - IRF	0	0					41.00
42.00	04200	SUBPROVIDER	0	0					42.00
43.00	04300	NURSERY	0	0					43.00
200.00		Total (lines 30-199)	0	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 12:55 pm
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Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col . 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	93,822	0	93,822	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	403	0	403	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	7,919	0	7,919	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 PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	65,769	0	65,769	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	33,659	0	33,659	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	201,572	0	201,572	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 12:55 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	93,822	44,103,076	0.002127	0.002127	8,221,572	50.00
51.00	05100 RECOVERY ROOM	0	3,589,019	0.000000	0.000000	639,593	51.00
53.00	05300 ANESTHESIOLOGY	0	9,458,996	0.000000	0.000000	1,759,764	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	403	38,798,389	0.000010	0.000010	3,686,304	54.00
57.00	05700 CT SCAN	0	42,807,335	0.000000	0.000000	4,648,485	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	51,479,671	0.000000	0.000000	9,299,730	60.00
65.00	06500 RESPIRATORY THERAPY	0	4,954,120	0.000000	0.000000	1,766,622	65.00
66.00	06600 PHYSICAL THERAPY	0	5,182,327	0.000000	0.000000	756,619	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,942,981	0.000000	0.000000	310,467	67.00
68.00	06800 SPEECH PATHOLOGY	0	819,503	0.000000	0.000000	93,465	68.00
69.00	06900 ELECTROCARDIOLOGY	7,919	28,875,750	0.000274	0.000274	4,812,682	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	964,203	0.000000	0.000000	82,096	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,154,439	0.000000	0.000000	2,597,985	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	27,412,555	0.000000	0.000000	8,007,636	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	68,922,921	0.000000	0.000000	15,829,053	73.00
76.97	07697 CARDIAC REHABILITATION	0	647,478	0.000000	0.000000	8,720	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	1,219,839	0.000000	0.000000	0	90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0	0	0.000000	0.000000	0	90.01
90.03	09002 PSYCH OUTPATIENT	0	0	0.000000	0.000000	0	90.03
90.04	09003 WOUND CARE CLINIC	0	7,560,155	0.000000	0.000000	146,249	90.04
91.00	09100 EMERGENCY	65,769	33,265,665	0.001977	0.001977	2,809,699	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	33,659	4,620,519	0.007285	0.007285	379,322	92.00
93.00	04040 OTHER OUTPATIENT SERVICES	0	0	0.000000	0.000000	0	93.00
200.00	Total (lines 50-199)	201,572	387,778,941			65,856,063	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 12:55 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PPS
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00	21.00	22.00	
50.00	05000 OPERATING ROOM	17,487	3,904,633	8,305	0	0	50.00
51.00	05100 RECOVERY ROOM	0	304,682	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	721,165	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	37	6,520,902	65	0	0	54.00
57.00	05700 CT SCAN	0	7,192,132	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	4,392,374	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	167,120	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	508	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	1,319	7,344,922	2,013	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	87,184	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,254,801	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	3,697,047	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5,297,721	0	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	266,840	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	33,814	0	0	0	90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002 PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003 WOUND CARE CLINIC	0	2,828,855	0	0	0	90.04
91.00	09100 EMERGENCY	5,555	3,574,520	7,067	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,763	1,073,100	7,818	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
200.00	Total (Lines 50-199)	27,161	48,662,320	25,268	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 12:55 pm
	Title XVIII	Hospital	PPS

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost		
	23.00	24.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 BASIC DIAGNOSTIC TESTING	0	0		90.01
90.03 09002 PSYCH OUTPATIENT	0	0		90.03
90.04 09003 WOUND CARE CLINIC	0	0		90.04
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00 04040 OTHER OUTPATIENT SERVICES	0	0		93.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/25/2016 12:55 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.276627	3,904,633	0	0	1,080,127	50.00
51.00 05100 RECOVERY ROOM	0.364236	304,682	0	0	110,976	51.00
53.00 05300 ANESTHESIOLOGY	0.026457	721,165	0	0	19,080	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.184210	6,520,902	4,240	0	1,201,215	54.00
57.00 05700 CT SCAN	0.033084	7,192,132	0	0	237,944	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00 06000 LABORATORY	0.104592	4,392,374	193	0	459,407	60.00
65.00 06500 RESPIRATORY THERAPY	0.348726	167,120	0	0	58,279	65.00
66.00 06600 PHYSICAL THERAPY	0.566313	508	0	0	288	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.237699	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.446610	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.178896	7,344,922	0	0	1,313,977	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.337795	87,184	0	0	29,450	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.133762	1,254,801	0	0	1,422,646	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.444523	3,697,047	0	0	1,643,422	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.130092	5,297,721	0	62,293	689,191	73.00
76.97 07697 CARDIAC REHABILITATION	1.091810	266,840	0	0	291,339	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.922413	33,814	0	0	31,190	90.00
90.01 09001 BASIC DIAGNOSTIC TESTING	0.000000	0	0	0	0	90.01
90.03 09002 PSYCH OUTPATIENT	0.000000	0	0	0	0	90.03
90.04 09003 WOUND CARE CLINIC	0.210032	2,828,855	0	0	594,150	90.04
91.00 09100 EMERGENCY	0.244451	3,574,520	0	0	873,795	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.727604	1,073,100	0	0	780,792	92.00
93.00 04040 OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
200.00	Subtotal (see instructions)	48,662,320	4,433	62,293	10,837,268	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0		201.00
202.00	Net Charges (line 200 +/- line 201)	48,662,320	4,433	62,293	10,837,268	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/25/2016 12:55 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	781	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	20	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	8,104		73.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 BASIC DIAGNOSTIC TESTING	0	0		90.01
90.03 09002 PSYCH OUTPATIENT	0	0		90.03
90.04 09003 WOUND CARE CLINIC	0	0		90.04
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00 04040 OTHER OUTPATIENT SERVICES	0	0		93.00
200.00 Subtotal (see instructions)	801	8,104		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	801	8,104		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140127 Component CCN: 14T127		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part II Date/Time Prepared: 5/25/2016 12:55 pm		
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,094,201	44,103,076	0.047484	15,733	747	50.00
51.00	05100	RECOVERY ROOM	81,184	3,589,019	0.022620	923	21	51.00
53.00	05300	ANESTHESIOLOGY	12,101	9,458,996	0.001279	2,318	3	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,600,815	38,798,389	0.041260	51,066	2,107	54.00
57.00	05700	CT SCAN	320,483	42,807,335	0.007487	32,957	247	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	577,015	51,479,671	0.011209	295,885	3,317	60.00
65.00	06500	RESPIRATORY THERAPY	158,112	4,954,120	0.031915	51,986	1,659	65.00
66.00	06600	PHYSICAL THERAPY	481,130	5,182,327	0.092841	626,783	58,191	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,115	1,942,981	0.003147	631,381	1,987	67.00
68.00	06800	SPEECH PATHOLOGY	5,158	819,503	0.006294	259,738	1,635	68.00
69.00	06900	ELECTROCARDIOLOGY	1,390,934	28,875,750	0.048170	13,499	650	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	47,800	964,203	0.049575	2,707	134	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	151,579	11,154,439	0.013589	60,949	828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	146,046	27,412,555	0.005328	13,935	74	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	341,205	68,922,921	0.004951	978,698	4,846	73.00
76.97	07697	CARDIAC REHABILITATION	66,524	647,478	0.102743	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	62,163	1,219,839	0.050960	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0.000000	0	0	90.03
90.04	09003	WOUND CARE CLINIC	68,629	7,560,155	0.009078	15,548	141	90.04
91.00	09100	EMERGENCY	602,522	33,265,665	0.018112	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,620,519	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	8,213,716	387,778,941		3,054,106	76,587	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140127 Component CCN: 14T127	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 12:55 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	93,822	0	93,822	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	403	0	403	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	7,919	0	7,919	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 PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	65,769	0	65,769	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	167,913	0	167,913	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140127 Component CCN: 14T127	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 12:55 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	93,822	44,103,076	0.002127	0.002127	15,733	50.00
51.00 05100 RECOVERY ROOM	0	3,589,019	0.000000	0.000000	923	51.00
53.00 05300 ANESTHESIOLOGY	0	9,458,996	0.000000	0.000000	2,318	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	403	38,798,389	0.000010	0.000010	51,066	54.00
57.00 05700 CT SCAN	0	42,807,335	0.000000	0.000000	32,957	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	51,479,671	0.000000	0.000000	295,885	60.00
65.00 06500 RESPIRATORY THERAPY	0	4,954,120	0.000000	0.000000	51,986	65.00
66.00 06600 PHYSICAL THERAPY	0	5,182,327	0.000000	0.000000	626,783	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	1,942,981	0.000000	0.000000	631,381	67.00
68.00 06800 SPEECH PATHOLOGY	0	819,503	0.000000	0.000000	259,738	68.00
69.00 06900 ELECTROCARDIOLOGY	7,919	28,875,750	0.000274	0.000274	13,499	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	964,203	0.000000	0.000000	2,707	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,154,439	0.000000	0.000000	60,949	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	27,412,555	0.000000	0.000000	13,935	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	68,922,921	0.000000	0.000000	978,698	73.00
76.97 07697 CARDIAC REHABILITATION	0	647,478	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	1,219,839	0.000000	0.000000	0	90.00
90.01 09001 BASIC DIAGNOSTIC TESTING	0	0	0.000000	0.000000	0	90.01
90.03 09002 PSYCH OUTPATIENT	0	0	0.000000	0.000000	0	90.03
90.04 09003 WOUND CARE CLINIC	0	7,560,155	0.000000	0.000000	15,548	90.04
91.00 09100 EMERGENCY	65,769	33,265,665	0.001977	0.001977	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	4,620,519	0.000000	0.000000	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICES	0	0	0.000000	0.000000	0	93.00
200.00 Total (lines 50-199)	167,913	387,778,941			3,054,106	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140127 Component CCN: 14T127	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 12:55 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	33	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1	0	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	4	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 PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03 09002 PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04 09003 WOUND CARE CLINIC	0	0	0	0	0	90.04
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
93.00 04040 OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
200.00 Total (lines 50-199)	38	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140127 Component CCN: 14T127	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 12:55 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0	0	90.01
90.03	09002 PSYCH OUTPATIENT	0	0	90.03
90.04	09003 WOUND CARE CLINIC	0	0	90.04
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICES	0	0	93.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/25/2016 12:55 pm
		Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.276627	0	1,319,442	0	0
51.00 05100 RECOVERY ROOM	0.364236	0	149,323	0	0
53.00 05300 ANESTHESIOLOGY	0.026457	0	287,262	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.184210	0	1,672,755	0	0
57.00 05700 CT SCAN	0.033084	0	1,655,350	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.104592	0	1,847,543	0	0
65.00 06500 RESPIRATORY THERAPY	0.348726	0	43,764	0	0
66.00 06600 PHYSICAL THERAPY	0.566313	0	108,078	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.237699	0	15,743	0	0
68.00 06800 SPEECH PATHOLOGY	0.446610	0	8,417	0	0
69.00 06900 ELECTROCARDIOLOGY	0.178896	0	346,173	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.337795	0	39,416	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.133762	0	184,604	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.444523	0	210,173	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.130092	0	1,415,945	0	0
76.97 07697 CARDIAC REHABILITATION	1.091810	0	8,838	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.922413	0	14,182	0	0
90.01 09001 BASIC DIAGNOSTIC TESTING	0.000000	0	0	0	0
90.03 09002 PSYCH OUTPATIENT	0.000000	0	0	0	0
90.04 09003 WOUND CARE CLINIC	0.210032	0	7,978	0	0
91.00 09100 EMERGENCY	0.244451	0	3,362,187	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.727604	0	215,882	0	0
93.00 04040 OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0
200.00 Subtotal (see instructions)		0	12,913,055	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 +/- line 201)		0	12,913,055	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/25/2016 12:55 pm
		Title XIX	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	364,993	0	50.00
51.00	05100 RECOVERY ROOM	54,389	0	51.00
53.00	05300 ANESTHESIOLOGY	7,600	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	308,138	0	54.00
57.00	05700 CT SCAN	54,766	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	193,238	0	60.00
65.00	06500 RESPIRATORY THERAPY	15,262	0	65.00
66.00	06600 PHYSICAL THERAPY	61,206	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,742	0	67.00
68.00	06800 SPEECH PATHOLOGY	3,759	0	68.00
69.00	06900 ELECTROCARDIOLOGY	61,929	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	13,315	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	209,297	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	93,427	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	184,203	0	73.00
76.97	07697 CARDIAC REHABILITATION	9,649	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	13,082	0	90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0	0	90.01
90.03	09002 PSYCH OUTPATIENT	0	0	90.03
90.04	09003 WOUND CARE CLINIC	1,676	0	90.04
91.00	09100 EMERGENCY	821,890	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	157,077	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICES	0	0	93.00
200.00	Subtotal (see instructions)	2,632,638	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	2,632,638	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/25/2016 12:55 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		24,130	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		24,130	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)		21,367	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		7,061	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)		29,360,328	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)		29,360,328	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)		29,360,328	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,216.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,591,542	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)		8,591,542	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140127		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/25/2016 12:55 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	9,450,617	7,780	1,214.73	2,929	3,557,944		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 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)					15,975,519		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					28,125,005		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,459,000		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,327,856		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,786,856		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					25,338,149		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)					2,763		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,216.76		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					3,361,908		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140127		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/25/2016 12:55 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,074,448	29,360,328	0.104714	3,361,908	352,039	90.00
91.00	Nursing School cost	0	29,360,328	0.000000	3,361,908	0	91.00
92.00	Allied health cost	293,949	29,360,328	0.010012	3,361,908	33,659	92.00
93.00	All other Medical Education	0	29,360,328	0.000000	3,361,908	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Component CCN: 14T127		Date/Time Prepared: 5/25/2016 12:55 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,923	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,923	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)		2,923	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)		1,762	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)		2,554,370	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)		2,554,370	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)		2,554,370	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)		873.89	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,539,794	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)		1,539,794	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140127		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
		Component CCN: 14T127				Date/Time Prepared: 5/25/2016 12:55 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							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)					894,570		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,434,364		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)					150,792		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					76,625		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					227,417		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,206,947		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140127 Component CCN: 14T127		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/25/2016 12:55 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	238,208	2,554,370	0.093255	0	0	90.00
91.00	Nursing School cost	0	2,554,370	0.000000	0	0	91.00
92.00	Allied health cost	11,946	2,554,370	0.004677	0	0	92.00
93.00	All other Medical Education	0	2,554,370	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/25/2016 12:55 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		10,958,950	30.00
31.00	03100	INTENSIVE CARE UNIT		5,015,770	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.276627	8,221,572	50.00
51.00	05100	RECOVERY ROOM	0.364236	639,593	51.00
53.00	05300	ANESTHESIOLOGY	0.026457	1,759,764	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184210	3,686,304	54.00
57.00	05700	CT SCAN	0.033084	4,648,485	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.104592	9,299,730	60.00
65.00	06500	RESPIRATORY THERAPY	0.348726	1,766,622	65.00
66.00	06600	PHYSICAL THERAPY	0.566313	756,619	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.237699	310,467	67.00
68.00	06800	SPEECH PATHOLOGY	0.446610	93,465	68.00
69.00	06900	ELECTROCARDIOLOGY	0.178896	4,812,682	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.337795	82,096	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.133762	2,597,985	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.444523	8,007,636	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130092	15,829,053	73.00
76.97	07697	CARDIAC REHABILITATION	1.091810	8,720	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.922413	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	90.03
90.04	09003	WOUND CARE CLINIC	0.210032	146,249	90.04
91.00	09100	EMERGENCY	0.244451	2,809,699	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.727604	379,322	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		65,856,063	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)		65,856,063	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140127 Component CCN: 14T127	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/25/2016 12:55 pm	
		Title XVIIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		1,824,491	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.276627	15,733	50.00
51.00	05100	RECOVERY ROOM	0.364236	923	51.00
53.00	05300	ANESTHESIOLOGY	0.026457	2,318	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184210	51,066	54.00
57.00	05700	CT SCAN	0.033084	32,957	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.104592	295,885	60.00
65.00	06500	RESPIRATORY THERAPY	0.348726	51,986	65.00
66.00	06600	PHYSICAL THERAPY	0.566313	626,783	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.237699	631,381	67.00
68.00	06800	SPEECH PATHOLOGY	0.446610	259,738	68.00
69.00	06900	ELECTROCARDIOLOGY	0.178896	13,499	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.337795	2,707	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.133762	60,949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.444523	13,935	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130092	978,698	73.00
76.97	07697	CARDIAC REHABILITATION	1.091810	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.922413	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	90.03
90.04	09003	WOUND CARE CLINIC	0.210032	15,548	90.04
91.00	09100	EMERGENCY	0.244451	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.727604	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		3,054,106	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)		3,054,106	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/25/2016 12:55 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,382,980	30.00
31.00	03100	INTENSIVE CARE UNIT		576,991	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		981,006	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.276627	496,185	137,258 50.00
51.00	05100	RECOVERY ROOM	0.364236	41,380	15,072 51.00
53.00	05300	ANESTHESIOLOGY	0.026457	139,027	3,678 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184210	413,784	76,223 54.00
57.00	05700	CT SCAN	0.033084	527,139	17,440 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.104592	1,142,743	119,522 60.00
65.00	06500	RESPIRATORY THERAPY	0.348726	152,837	53,298 65.00
66.00	06600	PHYSICAL THERAPY	0.566313	16,960	9,605 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.237699	6,482	1,541 67.00
68.00	06800	SPEECH PATHOLOGY	0.446610	4,160	1,858 68.00
69.00	06900	ELECTROCARDIOLOGY	0.178896	495,565	88,655 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.337795	10,428	3,523 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.133762	164,730	186,765 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.444523	128,374	57,065 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130092	1,925,009	250,428 73.00
76.97	07697	CARDIAC REHABILITATION	1.091810	1,538	1,679 76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.922413	0	0 90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0 90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	0 90.03
90.04	09003	WOUND CARE CLINIC	0.210032	3,937	827 90.04
91.00	09100	EMERGENCY	0.244451	293,792	71,818 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.727604	49,389	35,936 92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0 93.00
200.00		Total (sum of lines 50-94 and 96-98)		6,013,459	1,132,191 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		6,013,459	1,132,191 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3	
		Component CCN: 14T127		Date/Time Prepared: 5/25/2016 12:55 pm	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		66,885	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.276627	0	50.00
51.00	05100	RECOVERY ROOM	0.364236	0	51.00
53.00	05300	ANESTHESIOLOGY	0.026457	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184210	1,003	185 54.00
57.00	05700	CT SCAN	0.033084	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.104592	6,647	695 60.00
65.00	06500	RESPIRATORY THERAPY	0.348726	3,019	1,053 65.00
66.00	06600	PHYSICAL THERAPY	0.566313	19,926	11,284 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.237699	20,124	4,783 67.00
68.00	06800	SPEECH PATHOLOGY	0.446610	11,816	5,277 68.00
69.00	06900	ELECTROCARDIOLOGY	0.178896	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.337795	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.133762	3,444	3,905 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.444523	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130092	24,300	3,161 73.00
76.97	07697	CARDIAC REHABILITATION	1.091810	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.922413	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	90.03
90.04	09003	WOUND CARE CLINIC	0.210032	272	57 90.04
91.00	09100	EMERGENCY	0.244451	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.727604	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		90,551	30,400 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		90,551	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/25/2016 12:55 pm
		Title XVIII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		14,407,135	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,666,855	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)		373,443	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		7,449,274	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		197.95	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)		13.60	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.		1.03	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)		12.57	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		16.22	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)		12.57	12.00
13.00	Total allowable FTE count for the prior year.		12.57	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.		12.57	14.00
15.00	Sum of lines 12 through 14 divided by 3.		12.57	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		12.57	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.063501	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.069605	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.063501	21.00
22.00	IME payment adjustment (see instructions)		650,137	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		253,909	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)		3.65	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)		650,137	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		253,909	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.57	30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.91	31.00
32.00	Sum of lines 30 and 31		27.48	32.00
33.00	Allowable disproportionate share percentage (see instructions)		11.89	33.00
34.00	Disproportionate share adjustment (see instructions)		566,974	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/25/2016 12:55 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,451,359	1,158,327	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,085,537	291,164	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,376,701		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		22,041,245		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)		22,295,154		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,721,977		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).		406,019		52.00
53.00	Nursing and Allied Health Managed Care payment		77,439		53.00
54.00	Special add-on payments for new technologies		8,021		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		130,172		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		27,161		58.00
59.00	Total (sum of amounts on lines 49 through 58)		24,665,943		59.00
60.00	Primary payer payments		24,284		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		24,641,659		61.00
62.00	Deductibles billed to program beneficiaries		2,295,924		62.00
63.00	Coinurance billed to program beneficiaries		13,545		63.00
64.00	Allowable bad debts (see instructions)		373,105		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		242,518		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		245,653		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		22,574,708		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 PER PS&R		4,824		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)		34,252		70.93
70.94	HRR adjustment amount (see instructions)		-181,684		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/25/2016 12:55 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		22,432,100		71.00
71.01	Sequestration adjustment (see instructions)		448,642		71.01
72.00	Interim payments		21,791,905		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)		191,553		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		165,582		75.00
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140127		Period: From 01/01/2015 To 12/31/2015		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 5/25/2016 12:55 pm	
		PPS					
		Original .mcrcx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	4.57	0.00	0.00	4.57	4.57	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	22.91	0.00			22.91	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	27.48	0.00			27.48	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	197.95	0.00			197.95	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	11.89	0.00			11.89	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	4.57	0.00	0.00	4.57	4.57	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.21	0.00	0.00	4.57	4.57	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	2,420	0			2,420	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	1,532	0			1,532	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	3,890	0			3,890	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	7,842	0			7,842	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	33,375	0			33,375	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	416	0			416	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	437	0			437	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	34,228	0			34,228	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	22.91	0.00			22.91	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140127		Period: From 01/01/2015 To 12/31/2015		Worksheet DSH Date/Time Prepared: 5/25/2016 12:55 pm	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	11.89		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		11.89		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		11.89		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet DSH Date/Time Prepared: 5/25/2016 12:55 pm
		Title XVIII	Hospital	PPS

		Revised Percentage 6.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	11.89	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	11.89	30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	11.89	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/25/2016 12:55 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,905	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		10,812,000	2.00
3.00	PPS payments		9,265,598	3.00
4.00	Outlier payment (see instructions)		36,458	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.757	5.00
6.00	Line 2 times line 5		8,184,684	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		25,268	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		8,905	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		66,726	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)		66,726	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		66,726	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		57,821	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)		8,905	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)		9,327,324	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		1,792,403	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		874	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)		7,542,952	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		144,208	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)		7,687,160	30.00
31.00	Primary payer payments		817	31.00
32.00	Subtotal (line 30 minus line 31)		7,686,343	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)		296,740	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		192,881	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		219,477	36.00
37.00	Subtotal (see instructions)		7,879,224	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS PER PS&R		-198	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)		7,879,026	40.00
40.01	Sequestration adjustment (see instructions)		157,581	40.01
41.00	Interim payments		7,711,964	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		9,481	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
			Overrides	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0.112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140127

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

Worksheet E-1
Part I
Date/Time Prepared:
5/25/2016 12:55 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		21,626,547		7,707,673	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	08/04/2015	82,245	08/04/2015	9,574	3.01
3.02		12/15/2015	83,113		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0	12/15/2015	5,283	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)		165,358		4,291	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)		21,791,905		7,711,964	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		191,553		9,481	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		21,983,458		7,721,445	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140127
Component CCN: 14T127

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

Worksheet E-1
Part I
Date/Time Prepared:
5/25/2016 12:55 pm
PPS

Title XVIII

Subprovider -
IRF

		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		2,582,071		0	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	08/04/2015	16,282		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		16,282		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,598,353		0	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		11,025		0	6.02
7.00	Total Medicare program liability (see instructions)		2,587,328		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 140127

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

Worksheet E-1
Part II
Date/Time Prepared:
5/25/2016 12:55 pm

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			8,222 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			9,990 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3,794 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			29,147 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			451,162,493 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			13,259,186 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			415,898 8.00
9.00	Sequestration adjustment amount (see instructions)			8,318 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			407,580 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			434,829 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			-27,249 32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140127 Component CCN: 14T127	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part III Date/Time Prepared: 5/25/2016 12:55 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			2,582,283 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0021 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			57,585 3.00
4.00	Outlier Payments			20,383 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			8.008219 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			2,660,251 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			2,660,251 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			2,660,251 19.00
20.00	Deductibles			25,200 20.00
21.00	Subtotal (line 19 minus line 20)			2,635,051 21.00
22.00	Coinsurance			3,150 22.00
23.00	Subtotal (line 21 minus line 22)			2,631,901 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			1,516 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			985 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,516 26.00
27.00	Subtotal (sum of lines 23 and 25)			2,632,886 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			7,245 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			2,640,131 32.00
32.01	Sequestration adjustment (see instructions)			52,803 32.01
33.00	Interim payments			2,598,353 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)			-11,025 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			20,383 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet E-4 Date/Time Prepared: 5/25/2016 12:55 pm	
		Title XVII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			13.60	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			1.03	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			12.57	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			16.27	6.00
7.00	Enter the lesser of line 5 or line 6			12.57	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	6.76	9.50	16.26	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	5.22	7.34	12.56	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	5.22	7.34		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	5.33	6.81		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	5.76	6.30		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	5.44	6.82		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	5.44	6.82		17.00
18.00	Per resident amount	97,133.66	97,133.66		18.00
19.00	Approved amount for resident costs	528,407	662,452	1,190,859	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			3.70	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,190,859	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	11,752	3,794		26.00
27.00	Total Inpatient Days (see instructions)	32,486	32,486		27.00
28.00	Ratio of inpatient days to total inpatient days	0.361756	0.116789		28.00
29.00	Program direct GME amount	430,800	139,079		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		19,652		30.00
31.00	Net Program direct GME amount			550,227	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet E-4 Date/Time Prepared: 5/25/2016 12:55 pm
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		30,559,369	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		24,284	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		30,535,085	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		10,846,173	42.00
43.00	Primary payer payments (see instructions)		817	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		10,845,356	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		41,380,441	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.737911	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.262089	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		550,227	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		406,019	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		144,208	50.00

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

Provider CCN: 140127

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

Worksheet G

Date/Time Prepared:
5/25/2016 12:55 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	120,549,000	0	0	0	1.00
2.00	Temporary investments	81,893,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	518,635,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	172,222,000	0	0	0	9.00
10.00	Due from other funds	28,283,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	921,582,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	121,391,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	2,664,476,000	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,309,817,000	0	0	0	23.00
24.00	Accumulated depreciation	-2,158,727,000	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	1,936,957,000	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	4,096,861,000	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	352,448,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,449,309,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	7,307,848,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	314,213,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	344,980,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	70,871,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	460,696,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,190,760,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	1,501,836,000	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	936,798,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,438,634,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,629,394,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	3,678,454,000				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	3,678,454,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	7,307,848,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140127

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

Worksheet G-1

Date/Time Prepared:
5/25/2016 12:55 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		3,741,789,000		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		6,521,702			2.00
3.00	Total (sum of line 1 and line 2)		3,748,310,702		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		3,748,310,702		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00	ADJ TO AHC FUND BALANCE	69,856,702		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		69,856,702		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,678,454,000		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	ADJ TO AHC FUND BALANCE		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: 140127

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/25/2016 12:55 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	40,108,633		40,108,633	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	3,025,109		3,025,109	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	43,133,742		43,133,742	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	12,593,409		12,593,409	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	12,593,409		12,593,409	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	55,727,151		55,727,151	17.00
18.00	Ancillary services	165,118,399	191,727,694	356,846,093	18.00
19.00	Outpatient services	8,521,876	38,144,302	46,666,178	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	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)	229,367,426	229,871,996	459,239,422	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		168,386,184		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)		168,386,184		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140127

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

Worksheet G-3

Date/Time Prepared:
5/25/2016 12:55 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	459,239,422	1.00
2.00	Less contractual allowances and discounts on patients' accounts	292,332,516	2.00
3.00	Net patient revenues (line 1 minus line 2)	166,906,906	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	168,386,184	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,479,278	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	3,852,303	6.00
7.00	Income from investments	280,123	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	209,843	13.00
14.00	Revenue from meals sold to employees and guests	1,364,602	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	1,578,195	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	186,291	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	1,273,602	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	90,805	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	-834,784	24.00
25.00	Total other income (sum of lines 6-24)	8,000,980	25.00
26.00	Total (line 5 plus line 25)	6,521,702	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)	6,521,702	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140127	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/25/2016 12:55 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,515,368	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		53,102	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)		82.19	3.00
4.00	Number of interns & residents (see instructions)		12.57	4.00
5.00	Indirect medical education percentage (see instructions)		4.41	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)		66,828	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		4.57	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		22.91	8.00
9.00	Sum of lines 7 and 8		27.48	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.72	10.00
11.00	Disproportionate share adjustment (see instructions)		86,679	11.00
12.00	Total prospective capital payments (see instructions)		1,721,977	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