

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/29/2015 9:35 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/29/2015	Time: 9:35 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. ALEXIUS MEDICAL CENTER (140290) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 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	661,874	-62,458	-131,367	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	661,874	-62,458	-131,367	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140290		Period: From 07/01/2014 To 06/30/2015		Worksheet S-2 Part I Date/Time Prepared: 11/29/2015 9:34 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1555 BARRINGTON ROAD			PO Box:						1.00	
2.00	City: HOFFMAN ESTATES			State: IL		Zip Code: 60194		County: COOK		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
		V		XVIII		XIX					
3.00	Hospital and Hospital-Based Component Identification:										3.00
	Hospital		ST. ALEXIUS MEDICAL CENTER	140290	16974	1	09/16/1979	N	P	O	
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2014	06/30/2015		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	N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						1		N	23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	10,795	2,840	57	0	6,791	0		24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/29/2015 9:34 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.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/29/2015 9:34 pm																																																																																																																																																																											
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))																																																																																																																																																																											
		1.00	2.00	3.00																																																																																																																																																																											
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010																																																																																																																																																																															
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00																																																																																																																																																																										
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))																																																																																																																																																																									
		1.00	2.00	3.00	4.00	5.00																																																																																																																																																																									
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000																																																																																																																																																																									
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Inpatient Psychiatric Facility PPS</td> </tr> <tr> <td>70.00</td> <td>Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td>71.00</td> <td>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)</td> <td></td> <td></td> <td></td> <td></td> <td>0</td> </tr> <tr> <td colspan="7">Inpatient Rehabilitation Facility PPS</td> </tr> <tr> <td>75.00</td> <td>Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td>76.00</td> <td>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)</td> <td></td> <td></td> <td></td> <td></td> <td>0</td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Long Term Care Hospital PPS</td> </tr> <tr> <td>80.00</td> <td>Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td>81.00</td> <td>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.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td colspan="7">TEFRA Providers</td> </tr> <tr> <td>85.00</td> <td>Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td>86.00</td> <td>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.</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>87.00</td> <td>Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td>N</td> <td>Y</td> <td></td> </tr> <tr> <td>91.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> <td>N</td> <td></td> </tr> <tr> <td>92.00</td> <td>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.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td>93.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> <td>N</td> <td></td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? 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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)						106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.						107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N					108.00
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						109.00
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00	
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	0	0				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: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/29/2015 9:34 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	149019	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: ALEXIAN BROTHERS HOSPITAL NETWORK	Contractor's Name: WPS		Contractor's Number: 05901	
142.00	Street: 3040 SALT CREEK LANE	PO Box:		142.00	
143.00	City: ARLINGTON HEIGHTS,	State: IL		Zip Code: 60005	
				143.00	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y		144.00	
				1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00	
				1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00	
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
				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
		0	1.00	2.00	3.00
				CBSA	FTE/Campus
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)			0168.00	
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)	0.75		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)	07/01/2014		09/30/2014	
				170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/29/2015 9:34 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: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 11/29/2015 9:34 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)	N			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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			N	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/02/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 11/29/2015 9:34 pm
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TONY		LEONE	41.00
42.00	Enter the employer/company name of the cost report preparer.	LEONE CONSULTING			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	8472751023		TONY@LEONE-CONSULTING.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	11/02/2015	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONSULTANT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2015 9:34 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	243	88,695	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)		243	88,695	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	35	12,775	0.00	0	8.00
8.01 NEONATAL NICU	31.01	16	5,840	0.00	0	8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		294	107,310	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		294				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2015 9:34 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)	25,176	6,854	63,390			1.00
2.00 HMO and other (see instructions)	5,044	5,774				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	25,176	6,854	63,390			7.00
8.00 INTENSIVE CARE UNIT	2,180	286	5,088			8.00
8.01 NEONATAL NICU	0	2,325	7,671			8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		1,726	6,726			13.00
14.00 Total (see instructions)	27,356	11,191	82,875	0.00	1,479.35	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	1,479.35	27.00
28.00 Observation Bed Days		0	7,593			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2015 9:34 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	5,237	2,304	16,709	1.00
2.00 HMO and other (see instructions)			922	1,521		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
8.01 NEONATAL NICU						8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	5,237	2,304	16,709	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140290		Period: From 07/01/2014 To 06/30/2015		Worksheet S-3 Part II Date/Time Prepared: 11/29/2015 9:34 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	98,337,105	0	98,337,105	3,003,961.00	32.74	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		332,411	0	332,411	2,246.00	148.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		134,659	0	134,659	5,567.00	24.19	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		2,575,198	0	2,575,198	40,290.00	63.92	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		2,564,902	0	2,564,902	17,099.00	150.00	13.00
14.00	Home office salaries & wage-related costs		30,406,240	0	30,406,240	483,122.00	62.94	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)		22,783,297	0	22,783,297			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		31,241	0	31,241			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	118,432	0	118,432	4,108.00	28.83	26.00
27.00	Administrative & General	5.00	7,878,421	0	7,878,421	299,836.00	26.28	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	789,267	0	789,267	27,728.00	28.46	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		3,865,551	0	3,865,551	173,807.00	22.24	33.00
34.00	Dietary	10.00	67,553	-26,967	40,586	1,553.00	26.13	34.00
35.00	Dietary under contract (see instructions)		4,056,659	0	4,056,659	164,906.00	24.60	35.00
36.00	Cafeteria	11.00	0	26,967	26,967	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,900,702	0	1,900,702	40,195.00	47.29	38.00
39.00	Central Services and Supply	14.00	385,906	0	385,906	20,985.00	18.39	39.00
40.00	Pharmacy	15.00	3,330,696	0	3,330,696	82,981.00	40.14	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part II
Date/Time Prepared:
11/29/2015 9:34 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
41.00	Medical Records & Medical Records Library	16.00	1,228,360	0	1,228,360	68,018.00	18.06	41.00
42.00	Social Service	17.00	2,533,260	0	2,533,260	68,357.00	37.06	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part III
Date/Time Prepared:
11/29/2015 9:34 pm

	Worksheet A	Amount	Recl assi fi cation	Adjusted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Salaries	Related to	Wage (col. 4 ÷	
	1.00	2.00	(from	(col. 2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	105,926,904	0	105,926,904	3,340,428.00	31.71	1.00
2.00	Excluded area salaries (see instructions)	134,659	0	134,659	5,567.00	24.19	2.00
3.00	Subtotal salaries (line 1 minus line 2)	105,792,245	0	105,792,245	3,334,861.00	31.72	3.00
4.00	Subtotal other wages & related costs (see inst.)	35,546,340	0	35,546,340	540,511.00	65.76	4.00
5.00	Subtotal wage-related costs (see inst.)	22,783,297	0	22,783,297	0.00	21.54	5.00
6.00	Total (sum of lines 3 thru 5)	164,121,882	0	164,121,882	3,875,372.00	42.35	6.00
7.00	Total overhead cost (see instructions)	26,154,807	0	26,154,807	952,474.00	27.46	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet S-3 Part IV Date/Time Prepared: 11/29/2015 9:34 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,412,470	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		1,290,255	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		10,196,416	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		587,627	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		249,401	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)		585,009	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,014,752	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		7,127,795	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		108,338	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		242,477	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		22,814,540	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part V
Date/Time Prepared:
11/29/2015 9:34 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	2,575,198	0	1.00
2.00	Hospital	2,575,198	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-7

Date/Time Prepared:
11/29/2015 9:34 pm

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-7

Date/Time Prepared:
11/29/2015 9:34 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).					201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet S-10 Date/Time Prepared: 11/29/2015 9:34 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)		0.200865		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		55,315,309		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		271,037,921		6.00
7.00	Medicaid cost (line 1 times line 6)		54,442,032		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)		0		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)		0		19.00
				1.00	
				1.00	
				1.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	Uninsured patients	Insured patients	Total (col. 1 + col. 2)	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	27,143,649	-175,150	26,968,499	21.00
22.00	Partial payment by patients approved for charity care	5,452,209	-35,182	5,417,027	22.00
23.00	Cost of charity care (line 21 minus line 22)	0	0	0	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?	5,452,209	-35,182	5,417,027	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit				25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)				26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)				27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)				28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)				29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 140290		Period: From 07/01/2014 To 06/30/2015		Worksheet A	
Date/Time Prepared: 11/29/2015 9:34 pm							
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		14,553,261	14,553,261	7,255,387	21,808,648	1.00
2.00	00200		0	0	10,026,650	10,026,650	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	118,432	14,676,348	14,794,780	441,624	15,236,404	4.00
5.00	00500	7,878,421	77,183,325	85,061,746	-2,206,808	82,854,938	5.00
7.00	00700	789,267	5,371,709	6,160,976	-1,273	6,159,703	7.00
8.00	00800	0	0	0	1,160,531	1,160,531	8.00
9.00	00900	0	6,274,573	6,274,573	-1,167,743	5,106,830	9.00
10.00	01000	67,553	5,061,767	5,129,320	-2,040,229	3,089,091	10.00
11.00	01100	0	801,034	801,034	2,040,229	2,841,263	11.00
13.00	01300	1,900,702	510,923	2,411,625	-11,009	2,400,616	13.00
14.00	01400	385,906	765,467	1,151,373	-395,207	756,166	14.00
15.00	01500	3,330,696	14,684,623	18,015,319	-14,216,255	3,799,064	15.00
16.00	01600	1,228,360	1,039,318	2,267,678	-72	2,267,606	16.00
17.00	01700	2,533,260	279,417	2,812,677	0	2,812,677	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	27,733,558	7,561,270	35,294,828	-864,100	34,430,728	30.00
31.00	03100	4,529,531	1,188,713	5,718,244	-420,731	5,297,513	31.00
31.01	02060	5,338,646	1,220,631	6,559,277	-198,670	6,360,607	31.01
43.00	04300	643,545	53,668	697,213	-6,866	690,347	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	5,159,674	9,391,746	14,551,420	-6,536,554	8,014,866	50.00
50.01	05001	1,405,390	1,461,664	2,867,054	-1,094,915	1,772,139	50.01
51.00	05100	1,125,215	189,490	1,314,705	-53,233	1,261,472	51.00
52.00	05200	3,691,310	1,121,720	4,813,030	-439,123	4,373,907	52.00
53.00	05300	75,942	450,752	526,694	-237,905	288,789	53.00
54.00	05400	2,707,489	446,310	3,153,799	-38,361	3,115,438	54.00
54.01	03630	1,190,506	185,872	1,376,378	-45,684	1,330,694	54.01
54.02	05401	665,325	698,401	1,363,726	-584,489	779,237	54.02
54.03	03440	1,095,887	741,446	1,837,333	-530,288	1,307,045	54.03
55.00	05500	820,593	313,410	1,134,003	-220,175	913,828	55.00
56.00	05600	448,628	1,012,722	1,461,350	-4,718	1,456,632	56.00
57.00	05700	1,054,286	546,237	1,600,523	-411,787	1,188,736	57.00
58.00	05800	752,773	817,484	1,570,257	-704,979	865,278	58.00
59.00	05900	1,541,997	2,861,907	4,403,904	-2,487,169	1,916,735	59.00
60.00	06000	2,569,116	5,362,674	7,931,790	-111,163	7,820,627	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	407,176	901,424	1,308,600	-7,962	1,300,638	63.00
64.00	06400	237,371	383,338	620,709	-284,351	336,358	64.00
65.00	06500	2,636,861	1,457,874	4,094,735	-611,182	3,483,553	65.00
66.00	06600	1,819,944	167,318	1,987,262	-891	1,986,371	66.00
66.01	06601	1,388,711	522,240	1,910,951	-292,127	1,618,824	66.01
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	964,749	122,678	1,087,427	-15,801	1,071,626	69.00
70.00	07000	210,378	33,297	243,675	-4,815	238,860	70.00
71.00	07100	0	0	0	11,368,261	11,368,261	71.00
72.00	07200	0	11,800,173	11,800,173	2,290,022	14,090,195	72.00
73.00	07300	0	0	0	13,091,600	13,091,600	73.00
74.00	07400	0	808,172	808,172	0	808,172	74.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	2,326,366	917,788	3,244,154	-655,499	2,588,655	90.02
90.03	09004	0	0	0	0	0	90.03
90.04	09002	157,780	123,825	281,605	0	281,605	90.04
90.05	09003	441,398	336,468	777,866	-250,577	527,289	90.05
91.00	09100	6,829,704	3,286,293	10,115,997	-710,511	9,405,486	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		9,170,796	9,170,796	-9,170,796	0	113.00
118.00		98,202,446	206,859,566	305,062,012	640,286	305,702,298	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	131,499	652,486	783,985	0	783,985	190.00
192.00	19200	0	1,022,226	1,022,226	0	1,022,226	192.00
192.01	19201	0	3,506,124	3,506,124	-640,286	2,865,838	192.01
194.00	07950	3,160	242	3,402	0	3,402	194.00
194.01	07951	0	0	0	0	0	194.01
200.00		98,337,105	212,040,644	310,377,749	0	310,377,749	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet A
Date/Time Prepared:
11/29/2015 9:34 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,867,245	29,675,893	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,669,628	8,357,022	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	320,631	15,557,035	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-16,609,134	66,245,804	5.00
7.00	00700	OPERATION OF PLANT	4,175,458	10,335,161	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,160,531	8.00
9.00	00900	HOUSEKEEPING	0	5,106,830	9.00
10.00	01000	DIETARY	-14,749	3,074,342	10.00
11.00	01100	CAFETERIA	-1,061,162	1,780,101	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,400,616	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	756,166	14.00
15.00	01500	PHARMACY	-101	3,798,963	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	197,002	2,464,608	16.00
17.00	01700	SOCIAL SERVICE	0	2,812,677	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-834,860	33,595,868	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,297,513	31.00
31.01	02060	NEONATAL NICU	18,541	6,379,148	31.01
43.00	04300	NURSERY	0	690,347	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	8,014,866	50.00
50.01	05001	ENDOSCOPY	0	1,772,139	50.01
51.00	05100	RECOVERY ROOM	0	1,261,472	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,373,907	52.00
53.00	05300	ANESTHESIOLOGY	0	288,789	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,115,438	54.00
54.01	03630	ULTRASOUND	0	1,330,694	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	779,237	54.02
54.03	03440	MAMMOGRAPHY	0	1,307,045	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	913,828	55.00
56.00	05600	RADIOISOTOPE	0	1,456,632	56.00
57.00	05700	CT SCAN	0	1,188,736	57.00
58.00	05800	MRI	0	865,278	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,916,735	59.00
60.00	06000	LABORATORY	-22,947	7,797,680	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	-236	1,300,402	63.00
64.00	06400	INTRAVENOUS THERAPY	0	336,358	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,483,553	65.00
66.00	06600	PHYSICAL THERAPY	0	1,986,371	66.00
66.01	06601	REHAB OUTPATIENT	-7,035	1,611,789	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,071,626	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	238,860	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,368,261	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,090,195	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,091,600	73.00
74.00	07400	RENAL DIALYSIS	0	808,172	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.02	09001	PROCEDURE CLINIC	0	2,588,655	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	-28,080	253,525	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	527,289	90.05
91.00	09100	EMERGENCY	-10,132	9,395,354	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,679,187	298,023,111	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-447,634	336,351	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-895,603	126,623	192.00
192.01	19201	POB	-4,033,412	-1,167,574	192.01
194.00	07950	COMMUNITY PROGRAMS	0	3,402	194.00
194.01	07951	VACANT SPACE	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	-13,055,836	297,321,913	200.00

RECLASSIFICATIONS

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6

Date/Time Prepared:
11/29/2015 9:34 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RECLASS LEASE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,794,864	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,347,457	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
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	8,142,321	
B - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	11,368,261	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	85,353	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
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	11,453,614	
C - RECLASS CHARGEABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	13,091,600	1.00
TOTALS			0	13,091,600	

RECLASSIFICATIONS

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6

Date/Time Prepared:
11/29/2015 9:34 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	D - RECLASS DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,679,193	1.00
	TOTALS		0	4,679,193	
	E - RECLASS LAUNDRY COSTS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	1,160,531	1.00
	TOTALS		0	1,160,531	
	F - RECLASS CAFETERIA COSTGS				
1.00	CAFETERIA	11.00	26,967	2,013,262	1.00
	TOTALS		26,967	2,013,262	
	G - RECLASS WORKERS COMPENSATION				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	441,624	1.00
	TOTALS		0	441,624	
	H - RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,170,796	1.00
	TOTALS		0	9,170,796	
	I - RECLASS NEGATIVE SALARIES				
1.00		0.00	0	0	1.00
	TOTALS		0	0	
	J - IMPLANT RECLASS				
1.00	IMPL. DEV. CHARGED TO	72.00	0	2,431,286	1.00
	PATIENTS				
2.00	ANESTHESIOLOGY	53.00	0	404	2.00
3.00		0.00	0	0	3.00
4.00					4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	2,431,690	
500.00	Grand Total: Increases		26,967	52,584,631	500.00

RECLASSIFICATIONS

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6
Date/Time Prepared:
11/29/2015 9:34 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - RECLASS LEASE EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	31,080	10	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,850,537	10	2.00
3.00	OPERATION OF PLANT	7.00	0	1,273	0	3.00
4.00	HOUSEKEEPING	9.00	0	7,212	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	8,614	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	392,507	0	6.00
7.00	PHARMACY	15.00	0	807,396	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	72	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	205,170	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	61,499	0	10.00
11.00	NEONATAL NICU	31.01	0	9,361	0	11.00
13.00	OPERATING ROOM	50.00	0	839,659	0	13.00
14.00	ENDOSCOPY	50.01	0	537,565	0	14.00
15.00	RECOVERY ROOM	51.00	0	7,642	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	636	0	16.00
17.00	MAMMOGRAPHY	54.03	0	454,006	0	17.00
18.00	RADIOLOGY-THERAPEUTIC	55.00	0	212,655	0	18.00
19.00	CT SCAN	57.00	0	161,754	0	19.00
20.00	MRI	58.00	0	575,945	0	20.00
21.00	CARDIAC CATHETERIZATION	59.00	0	152,652	0	21.00
22.00	LABORATORY	60.00	0	105,111	0	22.00
23.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	6,664	0	23.00
24.00	RESPIRATORY THERAPY	65.00	0	508,305	0	24.00
25.00	PHYSICAL THERAPY	66.00	0	60	0	25.00
26.00	REHAB OUTPATIENT	66.01	0	291,166	0	26.00
27.00	ELECTROCARDIOLOGY	69.00	0	9,840	0	27.00
28.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,750	0	28.00
29.00	PROCEDURE CLINIC	90.02	0	20,531	0	29.00
30.00	OFFSITE IMAGING CENTER	90.05	0	238,921	0	30.00
31.00	EMERGENCY	91.00	0	2,452	0	31.00
32.00	POB	192.01	0	640,286	0	32.00
	TOTALS		0	8,142,321		
B - RECLASS MEDICAL SUPPLIES						
1.00		0.00	0	0	0	1.00
2.00	NURSING ADMINISTRATION	13.00	0	2,395	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,700	0	3.00
4.00	PHARMACY	15.00	0	317,259	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	658,930	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	359,131	0	6.00
7.00	NEONATAL NICU	31.01	0	189,309	0	7.00
8.00	NURSERY	43.00	0	6,866	0	8.00
9.00	OPERATING ROOM	50.00	0	5,696,895	0	9.00
10.00	ENDOSCOPY	50.01	0	477,337	0	10.00
11.00	RECOVERY ROOM	51.00	0	45,591	0	11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	431,253	0	12.00
13.00	ANESTHESIOLOGY	53.00	0	238,309	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	37,725	0	14.00
15.00	ULTRASOUND	54.01	0	45,684	0	15.00
16.00	RADIOLOGY-SPECIAL PROCEDURES	54.02	0	355,819	0	16.00
17.00	MAMMOGRAPHY	54.03	0	76,282	0	17.00
18.00	RADIOLOGY-THERAPEUTIC	55.00	0	7,520	0	18.00
19.00	RADIOISOTOPE	56.00	0	4,718	0	19.00
20.00	CT SCAN	57.00	0	250,033	0	20.00
21.00	MRI	58.00	0	129,034	0	21.00
22.00	CARDIAC CATHETERIZATION	59.00	0	740,799	0	22.00
23.00	LABORATORY	60.00	0	6,052	0	23.00
24.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	1,298	0	24.00
25.00	INTRAVENOUS THERAPY	64.00	0	284,351	0	25.00
26.00	RESPIRATORY THERAPY	65.00	0	102,877	0	26.00
27.00	PHYSICAL THERAPY	66.00	0	831	0	27.00
28.00	REHAB OUTPATIENT	66.01	0	961	0	28.00
29.00	ELECTROCARDIOLOGY	69.00	0	5,961	0	29.00
30.00	ELECTROENCEPHALOGRAPHY	70.00	0	4,815	0	30.00
31.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	139,514	0	31.00
32.00	PROCEDURE CLINIC	90.02	0	113,650	0	32.00
33.00	OFFSITE IMAGING CENTER	90.05	0	11,656	0	33.00
34.00	EMERGENCY	91.00	0	708,059	0	34.00
	TOTALS		0	11,453,614		

RECLASSIFICATIONS

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6

Date/Time Prepared:
11/29/2015 9:34 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
C - RECLASS CHARGEABLE DRUGS							
1.00	PHARMACY	15.00	0	13,091,600	0		1.00
	TOTALS		0	13,091,600			
D - RECLASS DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,679,193	9		1.00
	TOTALS		0	4,679,193			
E - RECLASS LAUNDRY COSTS							
1.00	HOUSEKEEPING	9.00	0	1,160,531	0		1.00
	TOTALS		0	1,160,531			
F - RECLASS CAFETERIA COSTGS							
1.00	DIETARY	10.00	26,967	2,013,262	0		1.00
	TOTALS		26,967	2,013,262			
G - RECLASS WORKERS COMPENSATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	441,624	0		1.00
	TOTALS		0	441,624			
H - RECLASS INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	9,170,796	11		1.00
	TOTALS		0	9,170,796			
I - RECLASS NEGATIVE SALARIES							
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
J - IMPLANT RECLASS							
1.00	INTENSIVE CARE UNIT	31.00	0	101	0		1.00
2.00	ENDOSCOPY	50.01	0	80,013	0		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	0	7,870	0		3.00
4.00	RADIOLOGY-SPECIAL PROCEDURES	54.02	0	228,670	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	1,593,718	0		5.00
6.00	PROCEDURE CLINIC	90.02	0	521,318	0		6.00
	TOTALS		0	2,431,690			
500.00	Grand Total: Decreases		26,967	52,584,631			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-7
Part I
Date/Time Prepared:
11/29/2015 9:34 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	12,220,000	0	0	0	0	1.00
2.00	Land Improvements	14,359	170,962	0	170,962	0	2.00
3.00	Buildings and Fixtures	222,807,634	145,957	0	145,957	0	3.00
4.00	Building Improvements	22,155,396	6,337,928	0	6,337,928	0	4.00
5.00	Fixed Equipment	1,265,074	195,531	0	195,531	0	5.00
6.00	Movable Equipment	34,447,764	3,044,586	0	3,044,586	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	292,910,227	9,894,964	0	9,894,964	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	292,910,227	9,894,964	0	9,894,964	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	12,220,000	0				1.00
2.00	Land Improvements	185,321	0				2.00
3.00	Buildings and Fixtures	222,953,591	0				3.00
4.00	Building Improvements	28,493,324	0				4.00
5.00	Fixed Equipment	1,460,605	0				5.00
6.00	Movable Equipment	37,492,350	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	302,805,191	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	302,805,191	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-7
Part II
Date/Time Prepared:
11/29/2015 9:34 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	14,553,261	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	14,553,261	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	14,553,261				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	14,553,261				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-7
Part III
Date/Time Prepared:
11/29/2015 9:34 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	253,092,842	0	253,092,842	0.870976	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	37,492,350	0	37,492,350	0.129024	0	2.00
3.00	Total (sum of lines 1-2)	290,585,192	0	290,585,192	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	17,874,441	2,763,784	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,009,565	5,347,457	2.00
3.00	Total (sum of lines 1-2)	0	0	0	20,884,006	8,111,241	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	9,037,668	0	0	0	29,675,893	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	8,357,022	2.00
3.00	Total (sum of lines 1-2)	9,037,668	0	0	0	38,032,915	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-133,128	CAP REL COSTS-BLDG & FIXT	1.00	11 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-20,000	CAP REL COSTS-MVBLE EQUIP	2.00	9 2.00
3.00 Investment income - other (chapter 2)		0		0.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0 7.00
8.00 Television and radio service (chapter 21)		0		0.00	0 8.00
9.00 Parking lot (chapter 21)		0		0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-859,498			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	-1,829,700			0 12.00
13.00 Laundry and linen service		0		0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-1,061,162	CAFETERIA	11.00	0 14.00
15.00 Rental of quarters to employee and others		0		0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0 16.00
17.00 Sale of drugs to other than patients		0		0.00	0 17.00
18.00 Sale of medical records and abstracts	B	-38,808	MEDICAL RECORDS & LIBRARY	16.00	0 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0 19.00
20.00 Vending machines	B	-14,749	DIETARY	10.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	-997,724	CAP REL COSTS-BLDG & FIXT	1.00	9 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,649,628	CAP REL COSTS-MVBLE EQUIP	2.00	9 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant		0		0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00	30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0 32.00
33.00		0		0.00	0 33.00
34.00		0		0.00	0 34.00

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	
34.01 CAFETERIA REVENUE	B	-447,634	GI FT, FLOWER, COFFEE SHOP & CANTEEN		190.00	0 34.01
34.02 LAB OTHER REVENUE	B	-19,958	LABORATORY		60.00	0 34.02
34.03 LAB OTHER REVENUE	B	-10	LABORATORY		60.00	0 34.03
34.04 LAB OTHER REVENUE	B	-32	LABORATORY		60.00	0 34.04
34.05 LAB OTHER REVENUE	B	-1,252	LABORATORY		60.00	0 34.05
34.06 LAB OTHER REVENUE	B	-1,695	LABORATORY		60.00	0 34.06
34.07 OTHER REVENUE	B	-236	BLOOD STORING, PROCESSING & TRANS.		63.00	0 34.07
35.00 ITC RENT REV ABSG	B	-46,347	POB		192.01	0 35.00
36.00 ITC RENT REV ABAG	B	-214,119	POB		192.01	0 36.00
37.00 ITC RENT REV ABSG	B	-83,438	POB		192.01	0 37.00
38.00 ITC RENT REV ABAG	B	-17,520	POB		192.01	0 38.00
38.01 ITC RENT REV ABSG	B	-197,138	ADMINISTRATIVE & GENERAL		5.00	0 38.01
39.00 ITC RENT REV ABAG	B	-44,313	ADMINISTRATIVE & GENERAL		5.00	0 39.00
40.00 PERINATAL CLASS TUITION	B	-52,533	ADMINISTRATIVE & GENERAL		5.00	0 40.00
41.00 OTHER EDUCATION	B	-591	ADMINISTRATIVE & GENERAL		5.00	0 41.00
42.00 AUDIT RECOVERIES INC	B	-1,800	ADMINISTRATIVE & GENERAL		5.00	0 42.00
43.00 MISCELLANEOUS INCOME	B	-192,982	ADMINISTRATIVE & GENERAL		5.00	0 43.00
43.01 PERINATAL CLASS TUITION	B	-3,442	ADULTS & PEDIATRICS		30.00	0 43.01
43.02 MISCELLANEOUS INCOME	B	-101	PHARMACY		15.00	0 43.02
43.03 RUNNERS CLINIC	B	-7,035	REHAB OUTPATIENT		66.01	0 43.03
43.04 MISCELLANEOUS INCOME	B	-38,081	OPERATION OF PLANT		7.00	0 43.04
43.05		0			0.00	0 43.05
43.06 MISCELLANEOUS INCOME	B	-7,128	ADMINISTRATIVE & GENERAL		5.00	0 43.06
43.07		0			0.00	0 43.07
43.08 RENT PHYS OFFICE	B	-17,895	POB		192.01	0 43.08
43.09 RENT PHYS OFFICE	B	-15,631	POB		192.01	0 43.09
43.10 RENT PHYS OFFICE	B	-273,383	POB		192.01	0 43.10
43.11 RENT PHYS OFFICE	B	-36,088	POB		192.01	0 43.11
43.12 RENT PHYS OFFICE	B	-1,238,966	POB		192.01	0 43.12
43.13 INCOME FROM EASEMENT	B	26,504	ADMINISTRATIVE & GENERAL		5.00	0 43.13
43.14 COMMUNITY TRANSPORT	A	-6,183	ADMINISTRATIVE & GENERAL		5.00	0 43.14
43.15 R/E TAXES	A	-261,156	ADMINISTRATIVE & GENERAL		5.00	0 43.15
43.16 CONTRIBUTIONS	A	-13,350	ADMINISTRATIVE & GENERAL		5.00	0 43.16
43.17 ER DIRECT PT SVSC	A	-10,132	EMERGENCY		91.00	0 43.17
43.18 NON PATIENT RELATED COSTS	A	-201,339	ADMINISTRATIVE & GENERAL		5.00	0 43.18
43.19 OFFSET PHYSICIAN FEES	A	-895,603	PHYSICIANS' PRIVATE OFFICES		192.00	0 43.19
43.20 OFFSET PHYSICIAN FEES	A	-557,018	POB		192.01	0 43.20
43.21 OFFSET PHYSICIAN FEES	A	-674,282	POB		192.01	0 43.21
43.22 OFFSET PHYSICIAN FEES	A	-858,725	POB		192.01	0 43.22
43.23 LOBBY DUES	A	-40,807	ADMINISTRATIVE & GENERAL		5.00	0 43.23
43.24		0			0.00	0 43.24
43.25 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 43.25
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,055,836				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-8-1

Date/Time Prepared:
11/29/2015 9:34 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	ABHN NON CAP	34,934,158	25,583,229 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	ABHS NON CAP	0	26,257,864 2.00
3.00	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	235,810	0 3.00
3.01	7.00	OPERATION OF PLANT	PLANT OPERATIONS	4,213,539	0 3.01
3.02	1.00	CAP REL COSTS-BLDG & FIXT	ABHN CAPITAL	8,998,097	0 3.02
3.03	31.01	NEONATAL NICU	ABHN A & P	18,541	0 3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	EXECUTIVE SALARIES	1,645,076	354,459 3.04
3.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	EXECUTIVE BENEFITS	320,631	0 3.05
3.06	0.00			0	0 3.06
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			50,365,852	52,195,552 5.00

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

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

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

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

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

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

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

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

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-8-1

Date/Time Prepared:
11/29/2015 9:34 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	9,350,929	0		1.00
2.00	-26,257,864	0		2.00
3.00	235,810	0		3.00
3.01	4,213,539	0		3.01
3.02	8,998,097	9		3.02
3.03	18,541	0		3.03
3.04	1,290,617	0		3.04
3.05	320,631	0		3.05
3.06	0	0		3.06
4.00	0	0		4.00
5.00	-1,829,700	0		5.00

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

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

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

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

6.00	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-8-2

Date/Time Prepared:
11/29/2015 9:34 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	831,418	831,418	0	0	0	1.00
2.00	90.04	EPILEPSY MONITORING UNIT	28,080	28,080	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			859,498	859,498	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	90.04	EPILEPSY MONITORING UNIT	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	831,418	1.00
2.00	90.04	EPILEPSY MONITORING UNIT	0	0	0	28,080	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	859,498	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part I
Date/Time Prepared:
11/29/2015 9:34 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	29,675,893	29,675,893			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	8,357,022		8,357,022		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	15,557,035	21,084	5,999	15,584,118	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	66,245,804	2,718,036	686,606	1,250,053	5.00
7.00 00700	OPERATION OF PLANT	10,335,161	8,094,182	2,303,068	125,231	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,160,531	0	0	0	8.00
9.00 00900	HOUSEKEEPING	5,106,830	340,305	96,828	0	9.00
10.00 01000	DIETARY	3,074,342	302,538	86,082	6,440	10.00
11.00 01100	CAFETERIA	1,780,101	219,586	62,480	4,279	11.00
13.00 01300	NURSING ADMINISTRATION	2,400,616	483,079	137,452	301,581	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	756,166	152,242	43,318	61,231	14.00
15.00 01500	PHARMACY	3,798,963	220,968	62,873	528,475	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,464,608	338,002	96,173	194,901	16.00
17.00 01700	SOCIAL SERVICE	2,812,677	14,789	4,208	401,947	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	33,595,868	6,784,958	1,930,548	4,400,386	30.00
31.00 03100	INTENSIVE CARE UNIT	5,297,513	552,061	157,080	718,692	31.00
31.01 02060	NEONATAL NICU	6,379,148	1,006,227	286,305	847,072	31.01
43.00 04300	NURSERY	690,347	65,502	18,638	102,110	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	8,014,866	1,685,864	479,685	818,675	50.00
50.01 05001	ENDOSCOPY	1,772,139	542,901	154,474	222,990	50.01
51.00 05100	RECOVERY ROOM	1,261,472	289,847	82,471	178,536	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,373,907	767,144	218,278	585,693	52.00
53.00 05300	ANESTHESIOLOGY	288,789	27,071	7,703	12,050	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,115,438	752,611	214,143	429,592	54.00
54.01 03630	ULTRASOUND	1,330,694	57,417	16,337	188,895	54.01
54.02 05401	RADIOLOGY-SPECIAL PROCEDURES	779,237	52,709	14,997	105,566	54.02
54.03 03440	MAMMOGRAPHY	1,307,045	251,109	71,449	173,882	54.03
55.00 05500	RADIOLOGY-THERAPEUTIC	913,828	635,986	180,959	130,202	55.00
56.00 05600	RADIOISOTOPE	1,456,632	108,846	30,970	71,183	56.00
57.00 05700	CT SCAN	1,188,736	136,327	38,789	167,281	57.00
58.00 05800	MRI	865,278	104,906	29,849	119,441	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,916,735	341,737	97,236	244,666	59.00
60.00 06000	LABORATORY	7,797,680	689,411	196,161	407,636	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	1,300,402	27,787	7,906	64,606	63.00
64.00 06400	INTRAVENOUS THERAPY	336,358	0	0	37,663	64.00
65.00 06500	RESPIRATORY THERAPY	3,483,553	73,537	20,924	418,385	65.00
66.00 06600	PHYSICAL THERAPY	1,986,371	273,625	77,856	288,767	66.00
66.01 06601	REHAB OUTPATIENT	1,611,789	6,090	1,733	220,344	66.01
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	1,071,626	0	0	153,075	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	238,860	28,453	8,096	33,380	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,368,261	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	14,090,195	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	13,091,600	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	808,172	0	0	0	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.02 09001	PROCEDURE CLINIC	2,588,655	326,078	92,780	369,120	90.02
90.03 09004	IMMEDIATE CARE CENTER	0	0	0	0	90.03
90.04 09002	EPILEPSY MONITORING UNIT	253,525	0	0	25,035	90.04
90.05 09003	OFFSITE IMAGING CENTER	527,289	0	0	70,036	90.05
91.00 09100	EMERGENCY	9,395,354	1,061,341	301,987	1,083,655	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	298,023,111	29,554,356	8,322,441	15,562,752	297,845,627
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	336,351	121,537	34,581	20,865	513,334
192.00 19200	PHYSICIANS' PRIVATE OFFICES	126,623	0	0	0	126,623
192.01 19201	POB	-1,167,574	0	0	0	-1,167,574
194.00 07950	COMMUNITY PROGRAMS	3,402	0	0	501	3,903
194.01 07951	VACANT SPACE	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part I
Date/Time Prepared:
11/29/2015 9:34 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
202.00 TOTAL (sum lines 118-201)	297,321,913	29,675,893	8,357,022	15,584,118	297,321,913	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet B Part I Date/Time Prepared: 11/29/2015 9:34 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	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	70,900,499			5.00
7.00	00700	OPERATION OF PLANT	6,497,760	27,355,402		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	361,539		1,522,070	8.00
9.00	00900	HOUSEKEEPING	1,727,105	494,049	0	7,765,117
10.00	01000	DIETARY	1,080,819	439,221	0	126,971
11.00	01100	CAFETERIA	643,758	318,792	0	92,157
13.00	01300	NURSING ADMINISTRATION	1,035,126	701,327	0	202,741
14.00	01400	CENTRAL SERVICES & SUPPLY	315,565	221,022	0	63,893
15.00	01500	PHARMACY	1,436,547	320,798	0	92,737
16.00	01600	MEDICAL RECORDS & LIBRARY	963,772	490,706	0	141,854
17.00	01700	SOCIAL SERVICE	1,007,367	21,471	0	6,207
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,551,999	9,850,306	867,256	2,847,541
31.00	03100	INTENSIVE CARE UNIT	2,095,140	801,474	76,046	231,691
31.01	02060	NEONATAL NICU	2,653,838	1,460,826	13,040	422,298
43.00	04300	NURSERY	273,085	95,095	0	27,490
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,426,536	2,447,513	180,048	707,530
50.01	05001	ENDOSCOPY	838,793	788,176	0	227,847
51.00	05100	RECOVERY ROOM	564,592	420,796	0	121,644
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,852,047	1,113,728	97,200	321,958
53.00	05300	ANESTHESIOLOGY	104,553	39,301	0	11,361
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,405,552	1,092,629	3,744	315,859
54.01	03630	ULTRASOUND	496,373	83,357	43,376	24,097
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	296,734	76,522	0	22,121
54.03	03440	MAMMOGRAPHY	561,838	364,556	0	105,386
55.00	05500	RADIOLOGY-THERAPEUTIC	579,748	923,315	11,571	266,913
56.00	05600	RADIOISOTOPE	519,515	158,022	0	45,681
57.00	05700	CT SCAN	476,992	197,917	53,242	57,214
58.00	05800	MRI	348,749	152,301	0	44,027
59.00	05900	CARDIAC CATHETERIZATION	810,092	496,130	0	143,422
60.00	06000	LABORATORY	2,832,075	1,000,877	0	289,335
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	436,359	40,341	0	11,662
64.00	06400	INTRAVENOUS THERAPY	116,518	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,244,994	106,759	0	30,862
66.00	06600	PHYSICAL THERAPY	818,268	397,245	0	114,836
66.01	06601	REHAB OUTPATIENT	573,200	8,841	0	2,556
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	381,530	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	96,197	41,307	0	11,941
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,541,543	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,389,504	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,078,413	0	0	0
74.00	07400	RENAL DIALYSIS	251,769	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.02	09001	PROCEDURE CLINIC	1,051,919	473,396	0	136,850
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0
90.04	09002	EPILEPSY MONITORING UNIT	86,780	0	0	0
90.05	09003	OFFSITE IMAGING CENTER	186,084	0	0	0
91.00	09100	EMERGENCY	3,689,231	1,540,840	176,547	445,428
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
118.00		SUBTOTALS (SUM OF LINES 1-117)	70,699,918	27,178,956	1,522,070	7,714,110
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	159,918	176,446	0	51,007
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,447	0	0	0
192.01	19201	POB	0	0	0	0
194.00	07950	COMMUNITY PROGRAMS	1,216	0	0	0
194.01	07951	VACANT SPACE	0	0	0	0
200.00		Cross Foot Adjustments				
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	70,900,499	27,355,402	1,522,070	7,765,117

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140290

Period: From 07/01/2014 To 06/30/2015

Worksheet B Part I Date/Time Prepared: 11/29/2015 9:34 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	3,121,153					11.00
13.00	01300		5,305,552				13.00
14.00	01400	25,788	0	1,639,225			14.00
15.00	01500	94,067	0	0	6,555,428		15.00
16.00	01600	76,062	0	0	0	4,766,078	16.00
17.00	01700	77,061	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,075,282	2,825,671	0	0	544,007	30.00
31.00	03100	132,447	348,050	0	0	70,775	31.00
31.01	02060	142,367	374,119	0	0	101,374	31.01
43.00	04300	18,051	47,436	0	0	31,020	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	159,233	418,442	0	0	407,766	50.00
50.01	05001	45,907	120,636	0	0	165,617	50.01
51.00	05100	30,364	79,793	0	0	74,381	51.00
52.00	05200	112,072	294,509	0	0	87,190	52.00
53.00	05300	4,182	0	0	0	96,507	53.00
54.00	05400	125,570	0	0	0	133,162	54.00
54.01	03630	30,945	0	0	0	102,833	54.01
54.02	05401	16,518	0	0	0	26,847	54.02
54.03	03440	35,336	0	0	0	52,595	54.03
55.00	05500	18,191	0	0	0	55,953	55.00
56.00	05600	10,733	0	0	0	76,225	56.00
57.00	05700	30,527	0	0	0	295,740	57.00
58.00	05800	22,373	0	0	0	145,845	58.00
59.00	05900	30,364	0	0	0	85,511	59.00
60.00	06000	134,677	0	0	0	576,860	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	15,844	0	0	0	24,908	63.00
64.00	06400	6,668	0	0	0	12,073	64.00
65.00	06500	91,372	0	0	0	129,048	65.00
66.00	06600	46,766	0	0	0	53,084	66.00
66.01	06601	44,745	0	0	0	32,249	66.01
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	32,595	0	0	0	107,407	69.00
70.00	07000	7,829	0	0	0	14,401	70.00
71.00	07100	0	0	810,273	0	263,897	71.00
72.00	07200	0	0	828,952	0	84,627	72.00
73.00	07300	0	0	0	6,555,428	412,775	73.00
74.00	07400	0	0	0	0	9,510	74.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	68,047	178,818	0	0	43,874	90.02
90.03	09004	0	0	0	0	0	90.03
90.04	09002	4,391	11,539	0	0	2,329	90.04
90.05	09003	15,101	0	0	0	42,439	90.05
91.00	09100	230,812	606,539	0	0	403,249	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		3,055,917	5,305,552	1,639,225	6,555,428	4,766,078	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	17,238	0	0	0	0	190.00
192.00	19200	12,313	0	0	0	0	192.00
192.01	19201	35,499	0	0	0	0	192.01
194.00	07950	186	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		3,121,153	5,305,552	1,639,225	6,555,428	4,766,078	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet B Part I Date/Time Prepared: 11/29/2015 9:34 pm
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE	4,345,727			17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,323,990	87,327,943	0	87,327,943	30.00
31.00	03100	INTENSIVE CARE UNIT	266,800	11,134,051	0	11,134,051	31.00
31.01	02060	NEONATAL NICU	402,245	14,088,859	0	14,088,859	31.01
43.00	04300	NURSERY	352,692	1,721,466	0	1,721,466	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	18,746,158	0	18,746,158	50.00
50.01	05001	ENDOSCOPY	0	4,879,480	0	4,879,480	50.01
51.00	05100	RECOVERY ROOM	0	3,103,896	0	3,103,896	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,823,726	0	9,823,726	52.00
53.00	05300	ANESTHESIOLOGY	0	591,517	0	591,517	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,588,300	0	7,588,300	54.00
54.01	03630	ULTRASOUND	0	2,374,324	0	2,374,324	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	1,391,251	0	1,391,251	54.02
54.03	03440	MAMMOGRAPHY	0	2,923,196	0	2,923,196	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,716,666	0	3,716,666	55.00
56.00	05600	RADIOISOTOPE	0	2,477,807	0	2,477,807	56.00
57.00	05700	CT SCAN	0	2,642,765	0	2,642,765	57.00
58.00	05800	MRI	0	1,832,769	0	1,832,769	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,165,893	0	4,165,893	59.00
60.00	06000	LABORATORY	0	13,924,712	0	13,924,712	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,929,815	0	1,929,815	63.00
64.00	06400	INTRAVENOUS THERAPY	0	509,280	0	509,280	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,599,434	0	5,599,434	65.00
66.00	06600	PHYSICAL THERAPY	0	4,056,818	0	4,056,818	66.00
66.01	06601	REHAB OUTPATIENT	0	2,501,547	0	2,501,547	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,746,233	0	1,746,233	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	480,464	0	480,464	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,983,974	0	15,983,974	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,393,278	0	19,393,278	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,138,216	0	24,138,216	73.00
74.00	07400	RENAL DIALYSIS	0	1,069,451	0	1,069,451	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	PROCEDURE CLINIC	0	5,329,537	0	5,329,537	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	383,599	0	383,599	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	840,949	0	840,949	90.05
91.00	09100	EMERGENCY	0	18,934,983	0	18,934,983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,345,727	297,352,357	0	297,352,357	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	917,943	0	917,943	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	178,383	0	178,383	192.00
192.01	19201	POB	0	-1,132,075	0	-1,132,075	192.01
194.00	07950	COMMUNITY PROGRAMS	0	5,305	0	5,305	194.00
194.01	07951	VACANT SPACE	0	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,345,727	297,321,913	0	297,321,913	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet B Part II Date/Time Prepared: 11/29/2015 9:34 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	21,084	5,999	27,083	27,083 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	2,718,036	686,606	3,404,642	2,174 5.00
7.00 00700	OPERATION OF PLANT	0	8,094,182	2,303,068	10,397,250	218 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00 00900	HOUSEKEEPING	0	340,305	96,828	437,133	0 9.00
10.00 01000	DIETARY	0	302,538	86,082	388,620	11 10.00
11.00 01100	CAFETERIA	0	219,586	62,480	282,066	7 11.00
13.00 01300	NURSING ADMINISTRATION	0	483,079	137,452	620,531	525 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	152,242	43,318	195,560	107 14.00
15.00 01500	PHARMACY	0	220,968	62,873	283,841	919 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	338,002	96,173	434,175	339 16.00
17.00 01700	SOCIAL SERVICE	0	14,789	4,208	18,997	699 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	6,784,958	1,930,548	8,715,506	7,629 30.00
31.00 03100	INTENSIVE CARE UNIT	0	552,061	157,080	709,141	1,250 31.00
31.01 02060	NEONATAL NICU	0	1,006,227	286,305	1,292,532	1,473 31.01
43.00 04300	NURSERY	0	65,502	18,638	84,140	178 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	1,685,864	479,685	2,165,549	1,424 50.00
50.01 05001	ENDOSCOPY	0	542,901	154,474	697,375	388 50.01
51.00 05100	RECOVERY ROOM	0	289,847	82,471	372,318	311 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	767,144	218,278	985,422	1,019 52.00
53.00 05300	ANESTHESIOLOGY	0	27,071	7,703	34,774	21 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	752,611	214,143	966,754	747 54.00
54.01 03630	ULTRASOUND	0	57,417	16,337	73,754	329 54.01
54.02 05401	RADIOLOGY-SPECIAL PROCEDURES	0	52,709	14,997	67,706	184 54.02
54.03 03440	MAMMOGRAPHY	0	251,109	71,449	322,558	302 54.03
55.00 05500	RADIOLOGY-THERAPEUTIC	0	635,986	180,959	816,945	226 55.00
56.00 05600	RADIOISOTOPE	0	108,846	30,970	139,816	124 56.00
57.00 05700	CT SCAN	0	136,327	38,789	175,116	291 57.00
58.00 05800	MRI	0	104,906	29,849	134,755	208 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	341,737	97,236	438,973	426 59.00
60.00 06000	LABORATORY	0	689,411	196,161	885,572	709 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	27,787	7,906	35,693	112 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	66 64.00
65.00 06500	RESPIRATORY THERAPY	0	73,537	20,924	94,461	728 65.00
66.00 06600	PHYSICAL THERAPY	0	273,625	77,856	351,481	502 66.00
66.01 06601	REHAB OUTPATIENT	0	6,090	1,733	7,823	383 66.01
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	266 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	28,453	8,096	36,549	58 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS						
90.02 09001	PROCEDURE CLINIC	0	326,078	92,780	418,858	642 90.02
90.03 09004	IMMEDIATE CARE CENTER	0	0	0	0	0 90.03
90.04 09002	EPILEPSY MONITORING UNIT	0	0	0	0	44 90.04
90.05 09003	OFFSITE IMAGING CENTER	0	0	0	0	122 90.05
91.00 09100	EMERGENCY	0	1,061,341	301,987	1,363,328	1,885 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	29,554,356	8,322,441	37,876,797	27,046 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	121,537	34,581	156,118	36 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
192.01 19201	POB	0	0	0	0	0 192.01
194.00 07950	COMMUNITY PROGRAMS	0	0	0	0	1 194.00
194.01 07951	VACANT SPACE	0	0	0	0	0 194.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	29,675,893	8,357,022	38,032,915	27,083 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet B Part II Date/Time Prepared: 11/29/2015 9:34 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	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,406,816			5.00
7.00	00700	OPERATION OF PLANT	312,218	10,709,686		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,372	0	17,372	8.00
9.00	00900	HOUSEKEEPING	82,988	193,421	0	713,542
10.00	01000	DIETARY	51,933	171,956	0	11,667
11.00	01100	CAFETERIA	30,933	124,808	0	8,468
13.00	01300	NURSING ADMINISTRATION	49,738	274,571	0	18,630
14.00	01400	CENTRAL SERVICES & SUPPLY	15,163	86,531	0	5,871
15.00	01500	PHARMACY	69,026	125,593	0	8,522
16.00	01600	MEDICAL RECORDS & LIBRARY	46,309	192,112	0	13,035
17.00	01700	SOCIAL SERVICE	48,404	8,406	0	570
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	699,265	3,856,411	9,898	261,665
31.00	03100	INTENSIVE CARE UNIT	100,672	313,779	868	21,290
31.01	02060	NEONATAL NICU	127,517	571,916	149	38,805
43.00	04300	NURSERY	13,122	37,230	0	2,526
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	164,645	958,206	2,055	65,015
50.01	05001	ENDOSCOPY	40,304	308,572	0	20,937
51.00	05100	RECOVERY ROOM	27,129	164,742	0	11,178
52.00	05200	DELIVERY ROOM & LABOR ROOM	88,991	436,027	1,109	29,585
53.00	05300	ANESTHESIOLOGY	5,024	15,386	0	1,044
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,537	427,766	43	29,024
54.01	03630	ULTRASOUND	23,851	32,634	495	2,214
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	14,258	29,958	0	2,033
54.03	03440	MAMMOGRAPHY	26,996	142,724	0	9,684
55.00	05500	RADIOLOGY-THERAPEUTIC	27,857	361,479	132	24,527
56.00	05600	RADIOISOTOPE	24,963	61,866	0	4,198
57.00	05700	CT SCAN	22,920	77,485	608	5,257
58.00	05800	MRI	16,757	59,626	0	4,046
59.00	05900	CARDIAC CATHETERIZATION	38,925	194,236	0	13,179
60.00	06000	LABORATORY	136,082	391,845	0	26,587
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	20,967	15,794	0	1,072
64.00	06400	INTRAVENOUS THERAPY	5,599	0	0	0
65.00	06500	RESPIRATORY THERAPY	59,822	41,796	0	2,836
66.00	06600	PHYSICAL THERAPY	39,318	155,522	0	10,552
66.01	06601	REHAB OUTPATIENT	27,542	3,461	0	235
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	18,333	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	4,622	16,172	0	1,097
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	170,171	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	210,916	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	195,968	0	0	0
74.00	07400	RENAL DIALYSIS	12,098	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.02	09001	PROCEDURE CLINIC	50,545	185,335	0	12,575
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0
90.04	09002	EPILEPSY MONITORING UNIT	4,170	0	0	0
90.05	09003	OFFSITE IMAGING CENTER	8,941	0	0	0
91.00	09100	EMERGENCY	177,268	603,241	2,015	40,931
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,397,179	10,640,607	17,372	708,855
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,684	69,079	0	4,687
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,895	0	0	0
192.01	19201	POB	0	0	0	0
194.00	07950	COMMUNITY PROGRAMS	58	0	0	0
194.01	07951	VACANT SPACE	0	0	0	0
200.00		Cross Foot Adjustments				
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,406,816	10,709,686	17,372	713,542
						624,187

ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 140290		Period: From 07/01/2014 To 06/30/2015		Worksheet B Part II Date/Time Prepared: 11/29/2015 9: 34 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	446,282					11.00
13.00	01300	6,239	970,234				13.00
14.00	01400	3,687	0	306,919			14.00
15.00	01500	13,450	0	0	501,351		15.00
16.00	01600	10,876	0	0	0	696,846	16.00
17.00	01700	11,019	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	153,746	516,734	0	0	79,574	30.00
31.00	03100	18,938	63,648	0	0	10,352	31.00
31.01	02060	20,357	68,416	0	0	14,828	31.01
43.00	04300	2,581	8,675	0	0	4,537	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	22,768	76,521	0	0	59,645	50.00
50.01	05001	6,564	22,061	0	0	24,225	50.01
51.00	05100	4,342	14,592	0	0	10,880	51.00
52.00	05200	16,025	53,857	0	0	12,754	52.00
53.00	05300	598	0	0	0	14,116	53.00
54.00	05400	17,955	0	0	0	19,478	54.00
54.01	03630	4,425	0	0	0	15,042	54.01
54.02	05401	2,362	0	0	0	3,927	54.02
54.03	03440	5,053	0	0	0	7,693	54.03
55.00	05500	2,601	0	0	0	8,184	55.00
56.00	05600	1,535	0	0	0	11,150	56.00
57.00	05700	4,365	0	0	0	43,259	57.00
58.00	05800	3,199	0	0	0	21,333	58.00
59.00	05900	4,342	0	0	0	12,508	59.00
60.00	06000	19,257	0	0	0	84,076	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	2,266	0	0	0	3,643	63.00
64.00	06400	953	0	0	0	1,766	64.00
65.00	06500	13,065	0	0	0	18,876	65.00
66.00	06600	6,687	0	0	0	7,765	66.00
66.01	06601	6,398	0	0	0	4,717	66.01
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	4,661	0	0	0	15,711	69.00
70.00	07000	1,119	0	0	0	2,107	70.00
71.00	07100	0	0	151,709	0	38,601	71.00
72.00	07200	0	0	155,210	0	12,379	72.00
73.00	07300	0	0	0	501,351	60,378	73.00
74.00	07400	0	0	0	0	1,391	74.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	9,730	32,701	0	0	6,418	90.02
90.03	09004	0	0	0	0	0	90.03
90.04	09002	628	2,110	0	0	341	90.04
90.05	09003	2,159	0	0	0	6,208	90.05
91.00	09100	33,003	110,919	0	0	58,984	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		436,953	970,234	306,919	501,351	696,846	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	2,465	0	0	0	0	190.00
192.00	19200	1,761	0	0	0	0	192.00
192.01	19201	5,076	0	0	0	0	192.01
194.00	07950	27	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		446,282	970,234	306,919	501,351	696,846	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet B Part II Date/Time Prepared: 11/29/2015 9:34 pm		
Cost Center	Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	88,095			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,383	14,944,873	0	14,944,873
31.00	03100	INTENSIVE CARE UNIT	5,408	1,292,471	0	1,292,471
31.01	02060	NEONATAL NICU	8,154	2,144,147	0	2,144,147
43.00	04300	NURSERY	7,150	160,139	0	160,139
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,515,828	0	3,515,828
50.01	05001	ENDOSCOPY	0	1,120,426	0	1,120,426
51.00	05100	RECOVERY ROOM	0	605,492	0	605,492
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,624,789	0	1,624,789
53.00	05300	ANESTHESIOLOGY	0	70,963	0	70,963
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,529,304	0	1,529,304
54.01	03630	ULTRASOUND	0	152,744	0	152,744
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	120,428	0	120,428
54.03	03440	MAMMOGRAPHY	0	515,010	0	515,010
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,241,951	0	1,241,951
56.00	05600	RADIOISOTOPE	0	243,652	0	243,652
57.00	05700	CT SCAN	0	329,301	0	329,301
58.00	05800	MRI	0	239,924	0	239,924
59.00	05900	CARDIAC CATHETERIZATION	0	702,589	0	702,589
60.00	06000	LABORATORY	0	1,544,128	0	1,544,128
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	79,547	0	79,547
64.00	06400	INTRAVENOUS THERAPY	0	8,384	0	8,384
65.00	06500	RESPIRATORY THERAPY	0	231,584	0	231,584
66.00	06600	PHYSICAL THERAPY	0	571,827	0	571,827
66.01	06601	REHAB OUTPATIENT	0	50,559	0	50,559
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	38,971	0	38,971
70.00	07000	ELECTROENCEPHALOGRAPHY	0	61,724	0	61,724
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	360,481	0	360,481
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	378,505	0	378,505
73.00	07300	DRUGS CHARGED TO PATIENTS	0	757,697	0	757,697
74.00	07400	RENAL DIALYSIS	0	13,489	0	13,489
76.97	07697	CARDIAC REHABILITATION	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.02	09001	PROCEDURE CLINIC	0	716,804	0	716,804
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0
90.04	09002	EPILEPSY MONITORING UNIT	0	7,293	0	7,293
90.05	09003	OFFSITE IMAGING CENTER	0	17,430	0	17,430
91.00	09100	EMERGENCY	0	2,391,574	0	2,391,574
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	88,095	37,784,028	0	37,784,028
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	240,069	0	240,069
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,656	0	3,656
192.01	19201	POB	0	5,076	0	5,076
194.00	07950	COMMUNITY PROGRAMS	0	86	0	86
194.01	07951	VACANT SPACE	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	88,095	38,032,915	0	38,032,915

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1
Date/Time Prepared:
11/29/2015 9:34 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	579,906				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		573,947			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	412	412	98,218,673		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	53,114	47,155	7,878,421	-70,900,499	5.00
7.00 00700	OPERATION OF PLANT	158,171	158,171	789,267	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	6,650	6,650	0	0	9.00
10.00 01000	DIETARY	5,912	5,912	40,586	0	10.00
11.00 01100	CAFETERIA	4,291	4,291	26,967	0	11.00
13.00 01300	NURSING ADMINISTRATION	9,440	9,440	1,900,702	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,975	2,975	385,906	0	14.00
15.00 01500	PHARMACY	4,318	4,318	3,330,696	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	6,605	6,605	1,228,360	0	16.00
17.00 01700	SOCIAL SERVICE	289	289	2,533,260	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	132,587	132,587	27,733,558	0	30.00
31.00 03100	INTENSIVE CARE UNIT	10,788	10,788	4,529,531	0	31.00
31.01 02060	NEONATAL NICU	19,663	19,663	5,338,646	0	31.01
43.00 04300	NURSERY	1,280	1,280	643,545	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	32,944	32,944	5,159,674	0	50.00
50.01 05001	ENDOSCOPY	10,609	10,609	1,405,390	0	50.01
51.00 05100	RECOVERY ROOM	5,664	5,664	1,125,215	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	14,991	14,991	3,691,310	0	52.00
53.00 05300	ANESTHESIOLOGY	529	529	75,942	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	14,707	14,707	2,707,489	0	54.00
54.01 03630	ULTRASOUND	1,122	1,122	1,190,506	0	54.01
54.02 05401	RADIOLOGY-SPECIAL PROCEDURES	1,030	1,030	665,325	0	54.02
54.03 03440	MAMMOGRAPHY	4,907	4,907	1,095,887	0	54.03
55.00 05500	RADIOLOGY-THERAPEUTIC	12,428	12,428	820,593	0	55.00
56.00 05600	RADIOISOTOPE	2,127	2,127	448,628	0	56.00
57.00 05700	CT SCAN	2,664	2,664	1,054,286	0	57.00
58.00 05800	MRI	2,050	2,050	752,773	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	6,678	6,678	1,541,997	0	59.00
60.00 06000	LABORATORY	13,472	13,472	2,569,116	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	543	543	407,176	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	237,371	0	64.00
65.00 06500	RESPIRATORY THERAPY	1,437	1,437	2,636,861	0	65.00
66.00 06600	PHYSICAL THERAPY	5,347	5,347	1,819,944	0	66.00
66.01 06601	REHAB OUTPATIENT	119	119	1,388,711	0	66.01
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	964,749	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	556	556	210,378	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.02 09001	PROCEDURE CLINIC	6,372	6,372	2,326,366	0	90.02
90.03 09004	IMMEDIATE CARE CENTER	0	0	0	0	90.03
90.04 09002	EPILEPSY MONITORING UNIT	0	0	157,780	0	90.04
90.05 09003	OFFSITE IMAGING CENTER	0	0	441,398	0	90.05
91.00 09100	EMERGENCY	20,740	20,740	6,829,704	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	577,531	571,572	98,084,014	-70,900,499	226,945,128
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,375	2,375	131,499	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	POB	0	0	0	1,167,574	192.01
194.00 07950	COMMUNITY PROGRAMS	0	0	3,160	0	194.00
194.01 07951	VACANT SPACE	0	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1
Date/Time Prepared:
11/29/2015 9:34 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)		
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					4.00
202.00	Cost to be allocated (per Wkst. B, Part I)	29,675,893	8,357,022	15,584,118		70,900,499	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	51.173626	14.560616	0.158668		0.311529	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			27,083		3,406,816	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000276		0.014969	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1

Date/Time Prepared:
11/29/2015 9:34 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	368,209				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,119,428			8.00	
9.00	00900	HOUSEKEEPING	6,650	0	361,559		9.00	
10.00	01000	DIETARY	5,912	0	5,912	67,392	10.00	
11.00	01100	CAFETERIA	4,291	0	4,291	0	11.00	
13.00	01300	NURSING ADMINISTRATION	9,440	0	9,440	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	2,975	0	2,975	0	14.00	
15.00	01500	PHARMACY	4,318	0	4,318	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	6,605	0	6,605	0	16.00	
17.00	01700	SOCIAL SERVICE	289	0	289	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	132,587	1,207,622	132,587	62,304	46,284	30.00
31.00	03100	INTENSIVE CARE UNIT	10,788	105,892	10,788	5,088	5,701	31.00
31.01	02060	NEONATAL NICU	19,663	18,158	19,663	0	6,128	31.01
43.00	04300	NURSERY	1,280	0	1,280	0	777	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,944	250,710	32,944	0	6,854	50.00
50.01	05001	ENDOSCOPY	10,609	0	10,609	0	1,976	50.01
51.00	05100	RECOVERY ROOM	5,664	0	5,664	0	1,307	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,991	135,347	14,991	0	4,824	52.00
53.00	05300	ANESTHESIOLOGY	529	0	529	0	180	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,707	5,214	14,707	0	5,405	54.00
54.01	03630	ULTRASOUND	1,122	60,400	1,122	0	1,332	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	1,030	0	1,030	0	711	54.02
54.03	03440	MAMMOGRAPHY	4,907	0	4,907	0	1,521	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	12,428	16,112	12,428	0	783	55.00
56.00	05600	RADIOISOTOPE	2,127	0	2,127	0	462	56.00
57.00	05700	CT SCAN	2,664	74,137	2,664	0	1,314	57.00
58.00	05800	MRI	2,050	0	2,050	0	963	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,678	0	6,678	0	1,307	59.00
60.00	06000	LABORATORY	13,472	0	13,472	0	5,797	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	543	0	543	0	682	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	287	64.00
65.00	06500	RESPIRATORY THERAPY	1,437	0	1,437	0	3,933	65.00
66.00	06600	PHYSICAL THERAPY	5,347	0	5,347	0	2,013	66.00
66.01	06601	REHAB OUTPATIENT	119	0	119	0	1,926	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1,403	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	556	0	556	0	337	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.02	09001	PROCEDURE CLINIC	6,372	0	6,372	0	2,929	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	0	0	0	189	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	0	0	0	650	90.05
91.00	09100	EMERGENCY	20,740	245,836	20,740	0	9,935	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	365,834	2,119,428	359,184	67,392	131,538	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,375	0	2,375	0	742	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	530	192.00
192.01	19201	POB	0	0	0	0	1,528	192.01
194.00	07950	COMMUNITY PROGRAMS	0	0	0	0	8	194.00
194.01	07951	VACANT SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	27,355,402	1,522,070	7,765,117	5,116,413	3,121,153	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	74.293138	0.718151	21.476763	75.920183	23.232199	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1

Date/Time Prepared:
11/29/2015 9:34 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	10,709,686	17,372	713,542	624,187	446,282	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	29.085889	0.008197	1.973515	9.262034	3.321885	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1

Date/Time Prepared:
11/29/2015 9:34 pm

Cost Center Description		NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	86,904					13.00
14.00	01400	0	22,998,613				14.00
15.00	01500	0	0	13,091,600			15.00
16.00	01600	0	0	0	1,480,360,997		16.00
17.00	01700	0	0	0	0	82,875	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	46,284	0	0	168,946,263	63,390	30.00
31.00	03100	5,701	0	0	21,979,711	5,088	31.00
31.01	02060	6,128	0	0	31,482,521	7,671	31.01
43.00	04300	777	0	0	9,633,402	6,726	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,854	0	0	126,635,415	0	50.00
50.01	05001	1,976	0	0	51,433,776	0	50.01
51.00	05100	1,307	0	0	23,099,687	0	51.00
52.00	05200	4,824	0	0	27,077,538	0	52.00
53.00	05300	0	0	0	29,971,057	0	53.00
54.00	05400	0	0	0	41,354,589	0	54.00
54.01	03630	0	0	0	31,935,792	0	54.01
54.02	05401	0	0	0	8,337,689	0	54.02
54.03	03440	0	0	0	16,333,710	0	54.03
55.00	05500	0	0	0	17,376,814	0	55.00
56.00	05600	0	0	0	23,672,233	0	56.00
57.00	05700	0	0	0	91,844,706	0	57.00
58.00	05800	0	0	0	45,293,344	0	58.00
59.00	05900	0	0	0	26,556,226	0	59.00
60.00	06000	0	0	0	179,362,219	0	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	0	0	0	7,735,369	0	63.00
64.00	06400	0	0	0	3,749,487	0	64.00
65.00	06500	0	0	0	40,077,075	0	65.00
66.00	06600	0	0	0	16,485,620	0	66.00
66.01	06601	0	0	0	10,015,220	0	66.01
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	33,356,341	0	69.00
70.00	07000	0	0	0	4,472,447	0	70.00
71.00	07100	0	11,368,261	0	81,955,636	0	71.00
72.00	07200	0	11,630,352	0	26,281,607	0	72.00
73.00	07300	0	0	13,091,600	128,190,901	0	73.00
74.00	07400	0	0	0	2,953,448	0	74.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	2,929	0	0	13,625,337	0	90.02
90.03	09004	0	0	0	0	0	90.03
90.04	09002	189	0	0	723,430	0	90.04
90.05	09003	0	0	0	13,179,925	0	90.05
91.00	09100	9,935	0	0	125,232,462	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		86,904	22,998,613	13,091,600	1,480,360,997	82,875	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		5,305,552	1,639,225	6,555,428	4,766,078	4,345,727	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1

Date/Time Prepared:
11/29/2015 9:34 pm

Cost Center Description		NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	61.050723	0.071275	0.500735	0.003220	52.437128	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	970,234	306,919	501,351	696,846	88,095	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	11.164434	0.013345	0.038296	0.000471	1.062986	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140290		Period: From 07/01/2014 To 06/30/2015		Worksheet C Part I Date/Time Prepared: 11/29/2015 9:34 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	87,327,943		87,327,943	0	87,327,943	30.00
31.00	03100	INTENSIVE CARE UNIT	11,134,051		11,134,051	0	11,134,051	31.00
31.01	02060	NEONATAL NICU	14,088,859		14,088,859	0	14,088,859	31.01
43.00	04300	NURSERY	1,721,466		1,721,466	0	1,721,466	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,746,158		18,746,158	0	18,746,158	50.00
50.01	05001	ENDOSCOPY	4,879,480		4,879,480	0	4,879,480	50.01
51.00	05100	RECOVERY ROOM	3,103,896		3,103,896	0	3,103,896	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,823,726		9,823,726	0	9,823,726	52.00
53.00	05300	ANESTHESIOLOGY	591,517		591,517	0	591,517	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,588,300		7,588,300	0	7,588,300	54.00
54.01	03630	ULTRASOUND	2,374,324		2,374,324	0	2,374,324	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	1,391,251		1,391,251	0	1,391,251	54.02
54.03	03440	MAMMOGRAPHY	2,923,196		2,923,196	0	2,923,196	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	3,716,666		3,716,666	0	3,716,666	55.00
56.00	05600	RADIOISOTOPE	2,477,807		2,477,807	0	2,477,807	56.00
57.00	05700	CT SCAN	2,642,765		2,642,765	0	2,642,765	57.00
58.00	05800	MRI	1,832,769		1,832,769	0	1,832,769	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,165,893		4,165,893	0	4,165,893	59.00
60.00	06000	LABORATORY	13,924,712		13,924,712	0	13,924,712	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,929,815		1,929,815	0	1,929,815	63.00
64.00	06400	INTRAVENOUS THERAPY	509,280		509,280	0	509,280	64.00
65.00	06500	RESPIRATORY THERAPY	5,599,434	0	5,599,434	0	5,599,434	65.00
66.00	06600	PHYSICAL THERAPY	4,056,818	0	4,056,818	0	4,056,818	66.00
66.01	06601	REHAB OUTPATIENT	2,501,547	0	2,501,547	0	2,501,547	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,746,233		1,746,233	0	1,746,233	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	480,464		480,464	0	480,464	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,983,974		15,983,974	0	15,983,974	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,393,278		19,393,278	0	19,393,278	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,138,216		24,138,216	0	24,138,216	73.00
74.00	07400	RENAL DIALYSIS	1,069,451		1,069,451	0	1,069,451	74.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.02	09001	PROCEDURE CLINIC	5,329,537		5,329,537	0	5,329,537	90.02
90.03	09004	IMMEDIATE CARE CENTER	0		0	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	383,599		383,599	0	383,599	90.04
90.05	09003	OFFSITE IMAGING CENTER	840,949		840,949	0	840,949	90.05
91.00	09100	EMERGENCY	18,934,983		18,934,983	0	18,934,983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,341,440		9,341,440	0	9,341,440	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	306,693,797	0	306,693,797	0	306,693,797	200.00
201.00		Less Observation Beds	9,341,440		9,341,440		9,341,440	201.00
202.00		Total (see instructions)	297,352,357	0	297,352,357	0	297,352,357	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140290		Period: From 07/01/2014 To 06/30/2015		Worksheet C Part I Date/Time Prepared: 11/29/2015 9:34 pm	
			Title XVIIII		Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	152,176,130		152,176,130			30.00
31.00	03100	INTENSIVE CARE UNIT	21,979,711		21,979,711			31.00
31.01	02060	NEONATAL NICU	31,482,521		31,482,521			31.01
43.00	04300	NURSERY	9,633,402		9,633,402			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	54,004,786	72,630,629	126,635,415	0.148033	0.000000	50.00
50.01	05001	ENDOSCOPY	10,076,413	41,357,363	51,433,776	0.094869	0.000000	50.01
51.00	05100	RECOVERY ROOM	9,962,317	13,137,370	23,099,687	0.134370	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,950,986	126,552	27,077,538	0.362800	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	12,193,518	17,777,539	29,971,057	0.019736	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,184,285	28,170,304	41,354,589	0.183494	0.000000	54.00
54.01	03630	ULTRASOUND	7,387,307	24,548,485	31,935,792	0.074347	0.000000	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	4,379,402	3,958,287	8,337,689	0.166863	0.000000	54.02
54.03	03440	MAMMOGRAPHY	4,255	16,329,455	16,333,710	0.178967	0.000000	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	571,440	16,805,374	17,376,814	0.213887	0.000000	55.00
56.00	05600	RADIOISOTOPE	7,936,598	15,735,635	23,672,233	0.104671	0.000000	56.00
57.00	05700	CT SCAN	25,038,351	66,806,355	91,844,706	0.028774	0.000000	57.00
58.00	05800	MRI	11,545,577	33,747,767	45,293,344	0.040464	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	15,288,418	11,267,808	26,556,226	0.156871	0.000000	59.00
60.00	06000	LABORATORY	84,156,279	95,205,940	179,362,219	0.077635	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,193,021	1,542,348	7,735,369	0.249479	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	3,424,790	324,697	3,749,487	0.135827	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	36,021,245	4,055,830	40,077,075	0.139717	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	15,714,448	771,172	16,485,620	0.246082	0.000000	66.00
66.01	06601	REHAB OUTPATIENT	4,044	10,011,176	10,015,220	0.249775	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	15,645,067	17,711,274	33,356,341	0.052351	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	934,044	3,538,403	4,472,447	0.107428	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,912,028	34,043,608	81,955,636	0.195032	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,081,778	8,199,829	26,281,607	0.737903	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	83,589,948	44,600,953	128,190,901	0.188299	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,953,448	0	2,953,448	0.362103	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.02	09001	PROCEDURE CLINIC	419,452	13,205,885	13,625,337	0.391149	0.000000	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0.000000	0.000000	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	723,430	723,430	0.530250	0.000000	90.04
90.05	09003	OFFSITE IMAGING CENTER	17,724	13,162,201	13,179,925	0.063805	0.000000	90.05
91.00	09100	EMERGENCY	30,587,352	94,645,110	125,232,462	0.151199	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,889,105	11,881,028	16,770,133	0.557028	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	764,339,190	716,021,807	1,480,360,997			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	764,339,190	716,021,807	1,480,360,997			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/29/2015 9:34 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
31.01	02060 NEONATAL NICU			31.01
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.148033		50.00
50.01	05001 ENDOSCOPY	0.094869		50.01
51.00	05100 RECOVERY ROOM	0.134370		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.362800		52.00
53.00	05300 ANESTHESIOLOGY	0.019736		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.183494		54.00
54.01	03630 ULTRASOUND	0.074347		54.01
54.02	05401 RADIOLOGY-SPECIAL PROCEDURES	0.166863		54.02
54.03	03440 MAMMOGRAPHY	0.178967		54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0.213887		55.00
56.00	05600 RADIOISOTOPE	0.104671		56.00
57.00	05700 CT SCAN	0.028774		57.00
58.00	05800 MRI	0.040464		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.156871		59.00
60.00	06000 LABORATORY	0.077635		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300 BLOOD STORAGE, PROCESSING & TRANS.	0.249479		63.00
64.00	06400 INTRAVENOUS THERAPY	0.135827		64.00
65.00	06500 RESPIRATORY THERAPY	0.139717		65.00
66.00	06600 PHYSICAL THERAPY	0.246082		66.00
66.01	06601 REHAB OUTPATIENT	0.249775		66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.052351		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.107428		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.195032		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.737903		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.188299		73.00
74.00	07400 RENAL DIALYSIS	0.362103		74.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
	OUTPATIENT SERVICE COST CENTERS			
90.02	09001 PROCEDURE CLINIC	0.391149		90.02
90.03	09004 IMMEDIATE CARE CENTER	0.000000		90.03
90.04	09002 EPILEPSY MONITORING UNIT	0.530250		90.04
90.05	09003 OFFSITE IMAGING CENTER	0.063805		90.05
91.00	09100 EMERGENCY	0.151199		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.557028		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/29/2015 9:34 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		87,327,943	0	87,327,943
31.00	03100 INTENSIVE CARE UNIT		11,134,051	0	11,134,051
31.01	02060 NEONATAL NICU		14,088,859	0	14,088,859
43.00	04300 NURSERY		1,721,466	0	1,721,466
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		18,746,158	0	18,746,158
50.01	05001 ENDOSCOPY		4,879,480	0	4,879,480
51.00	05100 RECOVERY ROOM		3,103,896	0	3,103,896
52.00	05200 DELIVERY ROOM & LABOR ROOM		9,823,726	0	9,823,726
53.00	05300 ANESTHESIOLOGY		591,517	0	591,517
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,588,300	0	7,588,300
54.01	03630 ULTRASOUND		2,374,324	0	2,374,324
54.02	05401 RADIOLOGY-SPECIAL PROCEDURES		1,391,251	0	1,391,251
54.03	03440 MAMMOGRAPHY		2,923,196	0	2,923,196
55.00	05500 RADIOLOGY-THERAPEUTIC		3,716,666	0	3,716,666
56.00	05600 RADIOISOTOPE		2,477,807	0	2,477,807
57.00	05700 CT SCAN		2,642,765	0	2,642,765
58.00	05800 MRI		1,832,769	0	1,832,769
59.00	05900 CARDIAC CATHETERIZATION		4,165,893	0	4,165,893
60.00	06000 LABORATORY		13,924,712	0	13,924,712
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		1,929,815	0	1,929,815
64.00	06400 INTRAVENOUS THERAPY		509,280	0	509,280
65.00	06500 RESPIRATORY THERAPY	0	5,599,434	0	5,599,434
66.00	06600 PHYSICAL THERAPY	0	4,056,818	0	4,056,818
66.01	06601 REHAB OUTPATIENT	0	2,501,547	0	2,501,547
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800 SPEECH PATHOLOGY	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY		1,746,233	0	1,746,233
70.00	07000 ELECTROENCEPHALOGRAPHY		480,464	0	480,464
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		15,983,974	0	15,983,974
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		19,393,278	0	19,393,278
73.00	07300 DRUGS CHARGED TO PATIENTS		24,138,216	0	24,138,216
74.00	07400 RENAL DIALYSIS		1,069,451	0	1,069,451
76.97	07697 CARDIAC REHABILITATION		0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.02	09001 PROCEDURE CLINIC		5,329,537	0	5,329,537
90.03	09004 IMMEDIATE CARE CENTER		0	0	0
90.04	09002 EPILEPSY MONITORING UNIT		383,599	0	383,599
90.05	09003 OFFSITE IMAGING CENTER		840,949	0	840,949
91.00	09100 EMERGENCY		18,934,983	0	18,934,983
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		9,341,440	0	9,341,440
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				
200.00	Subtotal (see instructions)		306,693,797	0	306,693,797
201.00	Less Observation Beds		9,341,440		9,341,440
202.00	Total (see instructions)		297,352,357	0	297,352,357

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140290		Period: From 07/01/2014 To 06/30/2015		Worksheet C Part I Date/Time Prepared: 11/29/2015 9:34 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	152,176,130		152,176,130			30.00
31.00	03100	INTENSIVE CARE UNIT	21,979,711		21,979,711			31.00
31.01	02060	NEONATAL NICU	31,482,521		31,482,521			31.01
43.00	04300	NURSERY	9,633,402		9,633,402			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	54,004,786	72,630,629	126,635,415	0.148033	0.000000	50.00
50.01	05001	ENDOSCOPY	10,076,413	41,357,363	51,433,776	0.094869	0.000000	50.01
51.00	05100	RECOVERY ROOM	9,962,317	13,137,370	23,099,687	0.134370	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,950,986	126,552	27,077,538	0.362800	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	12,193,518	17,777,539	29,971,057	0.019736	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,184,285	28,170,304	41,354,589	0.183494	0.000000	54.00
54.01	03630	ULTRASOUND	7,387,307	24,548,485	31,935,792	0.074347	0.000000	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	4,379,402	3,958,287	8,337,689	0.166863	0.000000	54.02
54.03	03440	MAMMOGRAPHY	4,255	16,329,455	16,333,710	0.178967	0.000000	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	571,440	16,805,374	17,376,814	0.213887	0.000000	55.00
56.00	05600	RADIOISOTOPE	7,936,598	15,735,635	23,672,233	0.104671	0.000000	56.00
57.00	05700	CT SCAN	25,038,351	66,806,355	91,844,706	0.028774	0.000000	57.00
58.00	05800	MRI	11,545,577	33,747,767	45,293,344	0.040464	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	15,288,418	11,267,808	26,556,226	0.156871	0.000000	59.00
60.00	06000	LABORATORY	84,156,279	95,205,940	179,362,219	0.077635	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,193,021	1,542,348	7,735,369	0.249479	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	3,424,790	324,697	3,749,487	0.135827	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	36,021,245	4,055,830	40,077,075	0.139717	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	15,714,448	771,172	16,485,620	0.246082	0.000000	66.00
66.01	06601	REHAB OUTPATIENT	4,044	10,011,176	10,015,220	0.249775	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	15,645,067	17,711,274	33,356,341	0.052351	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	934,044	3,538,403	4,472,447	0.107428	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,912,028	34,043,608	81,955,636	0.195032	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,081,778	8,199,829	26,281,607	0.737903	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	83,589,948	44,600,953	128,190,901	0.188299	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,953,448	0	2,953,448	0.362103	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.02	09001	PROCEDURE CLINIC	419,452	13,205,885	13,625,337	0.391149	0.000000	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0.000000	0.000000	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	723,430	723,430	0.530250	0.000000	90.04
90.05	09003	OFFSITE IMAGING CENTER	17,724	13,162,201	13,179,925	0.063805	0.000000	90.05
91.00	09100	EMERGENCY	30,587,352	94,645,110	125,232,462	0.151199	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,889,105	11,881,028	16,770,133	0.557028	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	764,339,190	716,021,807	1,480,360,997			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	764,339,190	716,021,807	1,480,360,997			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/29/2015 9:34 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
31.01	02060	NEONATAL NICU		31.01
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
50.01	05001	ENDOSCOPY	0.000000	50.01
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03630	ULTRASOUND	0.000000	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0.000000	54.02
54.03	03440	MAMMOGRAPHY	0.000000	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
66.01	06601	REHAB OUTPATIENT	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS				
90.02	09001	PROCEDURE CLINIC	0.000000	90.02
90.03	09004	IMMEDIATE CARE CENTER	0.000000	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0.000000	90.04
90.05	09003	OFFSITE IMAGING CENTER	0.000000	90.05
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140290		Period: From 07/01/2014 To 06/30/2015		Worksheet D Part I Date/Time Prepared: 11/29/2015 9:34 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	14,944,873	0	14,944,873	70,983	210.54	30.00
31.00	INTENSIVE CARE UNIT	1,292,471		1,292,471	5,088	254.02	31.00
31.01	NEONATAL NICU	2,144,147		2,144,147	7,671	279.51	31.01
43.00	NURSERY	160,139		160,139	6,726	23.81	43.00
200.00	Total (lines 30-199)	18,541,630		18,541,630	90,468		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	25,176	5,300,555				
31.00	INTENSIVE CARE UNIT	2,180	553,764				
31.01	NEONATAL NICU	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	27,356	5,854,319				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part II Date/Time Prepared: 11/29/2015 9:34 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	PPS		
						Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,515,828	126,635,415	0.027763	18,995,044	527,359	50.00
50.01	05001	ENDOSCOPY	1,120,426	51,433,776	0.021784	4,742,207	103,304	50.01
51.00	05100	RECOVERY ROOM	605,492	23,099,687	0.026212	3,508,555	91,966	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,624,789	27,077,538	0.060005	43,486	2,609	52.00
53.00	05300	ANESTHESIOLOGY	70,963	29,971,057	0.002368	4,115,150	9,745	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,529,304	41,354,589	0.036980	6,253,857	231,268	54.00
54.01	03630	ULTRASOUND	152,744	31,935,792	0.004783	3,445,827	16,481	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	120,428	8,337,689	0.014444	2,302,873	33,263	54.02
54.03	03440	MAMMOGRAPHY	515,010	16,333,710	0.031530	0	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	1,241,951	17,376,814	0.071472	233,576	16,694	55.00
56.00	05600	RADIOISOTOPE	243,652	23,672,233	0.010293	4,095,409	42,154	56.00
57.00	05700	CT SCAN	329,301	91,844,706	0.003585	11,971,771	42,919	57.00
58.00	05800	MRI	239,924	45,293,344	0.005297	4,734,896	25,081	58.00
59.00	05900	CARDIAC CATHETERIZATION	702,589	26,556,226	0.026457	6,412,577	169,658	59.00
60.00	06000	LABORATORY	1,544,128	179,362,219	0.008609	34,156,885	294,057	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	79,547	7,735,369	0.010284	1,688,976	17,369	63.00
64.00	06400	INTRAVENOUS THERAPY	8,384	3,749,487	0.002236	1,705,537	3,814	64.00
65.00	06500	RESPIRATORY THERAPY	231,584	40,077,075	0.005778	13,172,118	76,108	65.00
66.00	06600	PHYSICAL THERAPY	571,827	16,485,620	0.034686	8,663,091	300,488	66.00
66.01	06601	REHAB OUTPATIENT	50,559	10,015,220	0.005048	3,191	16	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	38,971	33,356,341	0.001168	7,943,764	9,278	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	61,724	4,472,447	0.013801	353,901	4,884	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	360,481	81,955,636	0.004398	18,348,253	80,696	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	378,505	26,281,607	0.014402	7,976,958	114,884	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	757,697	128,190,901	0.005911	32,282,916	190,824	73.00
74.00	07400	RENAL DIALYSIS	13,489	2,953,448	0.004567	2,556,248	11,674	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.02	09001	PROCEDURE CLINIC	716,804	13,625,337	0.052608	124,038	6,525	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0.000000	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	7,293	723,430	0.010081	0	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	17,430	13,179,925	0.001322	15,672	21	90.05
91.00	09100	EMERGENCY	2,391,574	125,232,462	0.019097	13,090,156	249,983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,598,647	16,770,133	0.095327	2,023,982	192,940	92.00
200.00		Total (lines 50-199)	20,841,045	1,265,089,233		214,960,914	2,866,062	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140290		Period: From 07/01/2014 To 06/30/2015		Worksheet D Part III Date/Time Prepared: 11/29/2015 9:34 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	02060	NEONATAL NICU	0	0	0	0	0	31.01
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	70,983	0.00	25,176	0		30.00
31.00	03100	INTENSIVE CARE UNIT	5,088	0.00	2,180	0		31.00
31.01	02060	NEONATAL NICU	7,671	0.00	0	0		31.01
43.00	04300	NURSERY	6,726	0.00	0	0		43.00
200.00		Total (lines 30-199)	90,468		27,356	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/29/2015 9:34 pm
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Cost Center Description	Title XVIII				Hospital	PPS
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
50.01 05001 ENDOSCOPY	0	0	0	0	0	50.01
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 03630 ULTRASOUND	0	0	0	0	0	54.01
54.02 05401 RADIOLOGY-SPECIAL PROCEDURES	0	0	0	0	0	54.02
54.03 03440 MAMMOGRAPHY	0	0	0	0	0	54.03
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 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
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01 06601 REHAB OUTPATIENT	0	0	0	0	0	66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.02 09001 PROCEDURE CLINIC	0	0	0	0	0	90.02
90.03 09004 IMMEDIATE CARE CENTER	0	0	0	0	0	90.03
90.04 09002 EPILEPSY MONITORING UNIT	0	0	0	0	0	90.04
90.05 09003 OFFSITE IMAGING CENTER	0	0	0	0	0	90.05
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00 Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/29/2015 9:34 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)	Hospital 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	0	126,635,415	0.000000	0.000000	18,995,044	50.00
50.01	05001 ENDOSCOPY	0	51,433,776	0.000000	0.000000	4,742,207	50.01
51.00	05100 RECOVERY ROOM	0	23,099,687	0.000000	0.000000	3,508,555	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	27,077,538	0.000000	0.000000	43,486	52.00
53.00	05300 ANESTHESIOLOGY	0	29,971,057	0.000000	0.000000	4,115,150	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	41,354,589	0.000000	0.000000	6,253,857	54.00
54.01	03630 ULTRASOUND	0	31,935,792	0.000000	0.000000	3,445,827	54.01
54.02	05401 RADIOLOGY-SPECIAL PROCEDURES	0	8,337,689	0.000000	0.000000	2,302,873	54.02
54.03	03440 MAMMOGRAPHY	0	16,333,710	0.000000	0.000000	0	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0	17,376,814	0.000000	0.000000	233,576	55.00
56.00	05600 RADIOISOTOPE	0	23,672,233	0.000000	0.000000	4,095,409	56.00
57.00	05700 CT SCAN	0	91,844,706	0.000000	0.000000	11,971,771	57.00
58.00	05800 MRI	0	45,293,344	0.000000	0.000000	4,734,896	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	26,556,226	0.000000	0.000000	6,412,577	59.00
60.00	06000 LABORATORY	0	179,362,219	0.000000	0.000000	34,156,885	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	7,735,369	0.000000	0.000000	1,688,976	63.00
64.00	06400 INTRAVENOUS THERAPY	0	3,749,487	0.000000	0.000000	1,705,537	64.00
65.00	06500 RESPIRATORY THERAPY	0	40,077,075	0.000000	0.000000	13,172,118	65.00
66.00	06600 PHYSICAL THERAPY	0	16,485,620	0.000000	0.000000	8,663,091	66.00
66.01	06601 REHAB OUTPATIENT	0	10,015,220	0.000000	0.000000	3,191	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	33,356,341	0.000000	0.000000	7,943,764	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	4,472,447	0.000000	0.000000	353,901	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	81,955,636	0.000000	0.000000	18,348,253	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	26,281,607	0.000000	0.000000	7,976,958	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	128,190,901	0.000000	0.000000	32,282,916	73.00
74.00	07400 RENAL DIALYSIS	0	2,953,448	0.000000	0.000000	2,556,248	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001 PROCEDURE CLINIC	0	13,625,337	0.000000	0.000000	124,038	90.02
90.03	09004 IMMEDIATE CARE CENTER	0	0	0.000000	0.000000	0	90.03
90.04	09002 EPILEPSY MONITORING UNIT	0	723,430	0.000000	0.000000	0	90.04
90.05	09003 OFFSITE IMAGING CENTER	0	13,179,925	0.000000	0.000000	15,672	90.05
91.00	09100 EMERGENCY	0	125,232,462	0.000000	0.000000	13,090,156	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	16,770,133	0.000000	0.000000	2,023,982	92.00
200.00	Total (lines 50-199)	0	1,265,089,233			214,960,914	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/29/2015 9:34 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)	Hospital	PPS
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00		
50.00	05000 OPERATING ROOM	0	11,148,668	0		50.00
50.01	05001 ENDOSCOPY	0	11,659,126	0		50.01
51.00	05100 RECOVERY ROOM	0	1,396,760	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	2,808,334	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,438,621	0		54.00
54.01	03630 ULTRASOUND	0	3,590,477	0		54.01
54.02	05401 RADIOLOGY-SPECIAL PROCEDURES	0	1,521,698	0		54.02
54.03	03440 MAMMOGRAPHY	0	899,353	0		54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0	6,486,255	0		55.00
56.00	05600 RADIOISOTOPE	0	5,418,187	0		56.00
57.00	05700 CT SCAN	0	14,841,656	0		57.00
58.00	05800 MRI	0	7,372,265	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	6,022,046	0		59.00
60.00	06000 LABORATORY	0	10,626,110	0		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
63.00	06300 BLOOD STORAGE, PROCESSING & TRANS.	0	249,883	0		63.00
64.00	06400 INTRAVENOUS THERAPY	0	166,632	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	757,377	0		65.00
66.00	06600 PHYSICAL THERAPY	0	122	0		66.00
66.01	06601 REHAB OUTPATIENT	0	389	0		66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	4,180,676	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	773,323	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,379,092	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,402,260	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	11,493,705	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
90.02	09001 PROCEDURE CLINIC	0	5,550,027	0		90.02
90.03	09004 IMMEDIATE CARE CENTER	0	0	0		90.03
90.04	09002 EPILEPSY MONITORING UNIT	0	26,068	0		90.04
90.05	09003 OFFSITE IMAGING CENTER	0	2,919,193	0		90.05
91.00	09100 EMERGENCY	0	11,808,081	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,475,597	0		92.00
200.00	Total (lines 50-199)	0	139,411,981	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/29/2015 9:34 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	0.148033	11,148,668	8,863	0	1,650,371	50.00
50.01 05001 ENDOSCOPY	0.094869	11,659,126	0	0	1,106,090	50.01
51.00 05100 RECOVERY ROOM	0.134370	1,396,760	0	0	187,683	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.362800	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.019736	2,808,334	0	0	55,425	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.183494	5,438,621	4,500	0	997,954	54.00
54.01 03630 ULTRASOUND	0.074347	3,590,477	0	0	266,941	54.01
54.02 05401 RADIOLOGY-SPECIAL PROCEDURES	0.166863	1,521,698	0	0	253,915	54.02
54.03 03440 MAMMOGRAPHY	0.178967	899,353	0	0	160,955	54.03
55.00 05500 RADIOLOGY-THERAPEUTIC	0.213887	6,486,255	0	0	1,387,326	55.00
56.00 05600 RADIO SOTOPE	0.104671	5,418,187	0	0	567,127	56.00
57.00 05700 CT SCAN	0.028774	14,841,656	0	0	427,054	57.00
58.00 05800 MRI	0.040464	7,372,265	0	0	298,311	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.156871	6,022,046	0	0	944,684	59.00
60.00 06000 LABORATORY	0.077635	10,626,110	10,771	0	824,958	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.249479	249,883	0	0	62,341	63.00
64.00 06400 INTRAVENOUS THERAPY	0.135827	166,632	0	0	22,633	64.00
65.00 06500 RESPIRATORY THERAPY	0.139717	757,377	0	0	105,818	65.00
66.00 06600 PHYSICAL THERAPY	0.246082	122	0	0	30	66.00
66.01 06601 REHAB OUTPATIENT	0.249775	389	0	0	97	66.01
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.052351	4,180,676	0	0	218,863	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.107428	773,323	0	0	83,077	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.195032	7,379,092	0	0	1,439,159	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.737903	2,402,260	0	0	1,772,635	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.188299	11,493,705	354	298,088	2,164,253	73.00
74.00 07400 RENAL DIALYSIS	0.362103	0	0	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.02 09001 PROCEDURE CLINIC	0.391149	5,550,027	0	0	2,170,888	90.02
90.03 09004 IMMEDIATE CARE CENTER	0.000000	0	0	0	0	90.03
90.04 09002 EPILEPSY MONITORING UNIT	0.530250	26,068	0	0	13,823	90.04
90.05 09003 OFFSITE IMAGING CENTER	0.063805	2,919,193	0	0	186,259	90.05
91.00 09100 EMERGENCY	0.151199	11,808,081	81,059	0	1,785,370	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.557028	2,475,597	0	0	1,378,977	92.00
200.00 Subtotal (see instructions)		139,411,981	105,547	298,088	20,533,017	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		139,411,981	105,547	298,088	20,533,017	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140290		Period: From 07/01/2014 To 06/30/2015		Worksheet D Part V Date/Time Prepared: 11/29/2015 9:34 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description		Costs					
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,312	0			50.00
50.01	05001	ENDOSCOPY	0	0			50.01
51.00	05100	RECOVERY ROOM	0	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300	ANESTHESIOLOGY	0	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	826	0			54.00
54.01	03630	ULTRASOUND	0	0			54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0			54.02
54.03	03440	MAMMOGRAPHY	0	0			54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0			55.00
56.00	05600	RADIOISOTOPE	0	0			56.00
57.00	05700	CT SCAN	0	0			57.00
58.00	05800	MRI	0	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000	LABORATORY	836	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
64.00	06400	INTRAVENOUS THERAPY	0	0			64.00
65.00	06500	RESPIRATORY THERAPY	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0			66.00
66.01	06601	REHAB OUTPATIENT	0	0			66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	67	56,130			73.00
74.00	07400	RENAL DIALYSIS	0	0			74.00
76.97	07697	CARDIAC REHABILITATION	0	0			76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	PROCEDURE CLINIC	0	0			90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0			90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	0			90.04
90.05	09003	OFFSITE IMAGING CENTER	0	0			90.05
91.00	09100	EMERGENCY	12,256	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.00
200.00		Subtotal (see instructions)	15,297	56,130			200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0				201.00
202.00		Net Charges (line 200 +/- line 201)	15,297	56,130			202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/29/2015 9:34 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		70,983	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		70,983	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		63,390	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)		25,176	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)		87,327,943	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)		87,327,943	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)		87,327,943	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)		1,230.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		30,973,278	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)		30,973,278	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1	
		Title XVIII		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	11,134,051	5,088	2,188.30	2,180	4,770,494	43.00
43.01	NEONATAL NICU	14,088,859	7,671	1,836.64	0	0	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					34,995,867	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					70,739,639	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					5,854,319	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,866,062	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					8,720,381	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					62,019,258	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)					7,593	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,230.27	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					9,341,440	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/29/2015 9:34 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	14,944,873	87,327,943	0.171135	9,341,440	1,598,647	90.00
91.00	Nursing School cost	0	87,327,943	0.000000	9,341,440	0	91.00
92.00	Allied health cost	0	87,327,943	0.000000	9,341,440	0	92.00
93.00	All other Medical Education	0	87,327,943	0.000000	9,341,440	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/29/2015 9:34 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		70,983	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		70,983	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		63,390	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)		6,854	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)		6,726	15.00
16.00	Nursery days (title V or XIX only)		1,726	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)		87,327,943	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)		87,327,943	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)		87,327,943	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)		1,230.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,432,271	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)		8,432,271	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1	
		Title XIX		Hospital		Date/Time Prepared: 11/29/2015 9:34 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,721,466	6,726	255.94	1,726	441,752	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	11,134,051	5,088	2,188.30	286	625,854	43.00
43.01	NEONATAL NICU	14,088,859	7,671	1,836.64	2,325	4,270,188	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					13,770,065	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					7,593	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,230.27	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					9,341,440	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/29/2015 9:34 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	14,944,873	87,327,943	0.171135	9,341,440	1,598,647	90.00
91.00	Nursing School cost	0	87,327,943	0.000000	9,341,440	0	91.00
92.00	Allied health cost	0	87,327,943	0.000000	9,341,440	0	92.00
93.00	All other Medical Education	0	87,327,943	0.000000	9,341,440	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Prepared: 11/29/2015 9:34 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		58,601,987	30.00
31.00	03100	INTENSIVE CARE UNIT		10,713,198	31.00
31.01	02060	NEONATAL NICU		0	31.01
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.148033	18,995,044	50.00
50.01	05001	ENDOSCOPY	0.094869	4,742,207	50.01
51.00	05100	RECOVERY ROOM	0.134370	3,508,555	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.362800	43,486	52.00
53.00	05300	ANESTHESIOLOGY	0.019736	4,115,150	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183494	6,253,857	54.00
54.01	03630	ULTRASOUND	0.074347	3,445,827	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0.166863	2,302,873	54.02
54.03	03440	MAMMOGRAPHY	0.178967	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0.213887	233,576	55.00
56.00	05600	RADIOISOTOPE	0.104671	4,095,409	56.00
57.00	05700	CT SCAN	0.028774	11,971,771	57.00
58.00	05800	MRI	0.040464	4,734,896	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.156871	6,412,577	59.00
60.00	06000	LABORATORY	0.077635	34,156,885	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.249479	1,688,976	63.00
64.00	06400	INTRAVENOUS THERAPY	0.135827	1,705,537	64.00
65.00	06500	RESPIRATORY THERAPY	0.139717	13,172,118	65.00
66.00	06600	PHYSICAL THERAPY	0.246082	8,663,091	66.00
66.01	06601	REHAB OUTPATIENT	0.249775	3,191	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.052351	7,943,764	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.107428	353,901	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.195032	18,348,253	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.737903	7,976,958	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188299	32,282,916	73.00
74.00	07400	RENAL DIALYSIS	0.362103	2,556,248	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.02	09001	PROCEDURE CLINIC	0.391149	124,038	90.02
90.03	09004	IMMEDIATE CARE CENTER	0.000000	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0.530250	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	0.063805	15,672	90.05
91.00	09100	EMERGENCY	0.151199	13,090,156	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.557028	2,023,982	92.00
200.00		Total (sum of lines 50-94 and 96-98)		214,960,914	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)		214,960,914	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prepared: 11/29/2015 9:34 pm	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	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)		11,170,537		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		33,511,611		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0		1.04
2.00	Outlier payments for discharges. (see instructions)		1,766,013		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		273.20		4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prepared: 11/29/2015 9:34 pm	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	2.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	1.01	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.42		30.00
31.00	Percentage of Medicaid patient days (see instructions)		24.72		31.00
32.00	Sum of lines 30 and 31		27.14		32.00
33.00	Allowable disproportionate share percentage (see instructions)		11.61		33.00
34.00	Disproportionate share adjustment (see instructions)		1,296,900		34.00
			Prior to October 1	On/After October 1	
		0	1.00	1.01	2.00
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000525065	0.000523947	35.01
35.02	Hospital uncompensated care payment (if line 34 is zero, enter zero on this line) (see instructions)		4,749,941	4,006,961	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,197,246	2,996,986	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		4,194,232		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	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 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	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)		51,939,293		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)		51,939,293		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,971,671		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		55,910,964		59.00
60.00	Primary payer payments		419,637		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		55,491,327		61.00
62.00	Deductibles billed to program beneficiaries		4,456,680		62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prepared: 11/29/2015 9:34 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00
63.00	Coinurance billed to program beneficiaries		245,276		63.00
64.00	Allowable bad debts (see instructions)		871,201		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		566,281		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		585,556		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		51,355,652		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.01	OTHER ADJUSTMENTS		0		70.01
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	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)		34,534		70.93
70.94	HRR adjustment amount (see instructions)		-119,563		70.94
70.95	Recovery of accelerated depreciation		0		70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		51,270,623		71.00
71.01	Sequestration adjustment (see instructions)		1,025,412		71.01
72.00	Interim payments		49,583,337		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)		661,874		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		116,401		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. 1, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prepared: 11/29/2015 9:34 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1		On/After 10/1
		1.00	1.01	2.00
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0		0
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0		0
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0		0
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000		0.0000
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0		0

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/29/2015 9:34 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		71,427	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		20,533,017	2.00
3.00	PPS payments		19,526,535	3.00
4.00	Outlier payment (see instructions)		57,234	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		71,427	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		403,635	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)		403,635	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)		403,635	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		332,208	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)		71,427	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)		19,583,769	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		4,223,589	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)		15,431,607	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		15,431,607	30.00
31.00	Primary payer payments		48,453	31.00
32.00	Subtotal (line 30 minus line 31)		15,383,154	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)		738,870	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		480,266	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		580,875	36.00
37.00	Subtotal (see instructions)		15,863,420	37.00
38.00	MSP-LCC reconciliation amount from PS&R		5,213	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		15,858,207	40.00
40.01	Sequestration adjustment (see instructions)		317,164	40.01
41.00	Interim payments		15,603,501	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-62,458	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
11/29/2015 9:34 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		49,102,723		15,035,853	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		397,214		459,948	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	01/30/2015	83,400	01/30/2015	107,700	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)		83,400		107,700	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)		49,583,337		15,603,501	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		661,874		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		62,458	6.02
7.00	Total Medicare program liability (see instructions)		50,245,211		15,541,043	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet E-1
Part II
Date/Time Prepared:
11/29/2015 9:34 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	16,709	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	27,356	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	5,044	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	76,149	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	1,480,360,997	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	26,968,499	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1,661,656	8.00
9.00	Sequestration adjustment amount (see instructions)	33,233	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,628,423	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)	1,759,790	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)	-131,367	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 11/29/2015 9:34 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		13,770,065		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		13,770,065	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		13,770,065	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		13,770,065	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		13,770,065	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet G

Date/Time Prepared:
11/29/2015 9:34 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	12,845	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	50,639,790	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	4,106,153	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	300,617	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	55,059,405	0	0	0	11.00
FIXED ASSETS						
12.00	Land	12,220,000	0	0	0	12.00
13.00	Land improvements	185,321	0	0	0	13.00
14.00	Accumulated depreciation	-8,455	0	0	0	14.00
15.00	Buildings	222,953,592	0	0	0	15.00
16.00	Accumulated depreciation	-22,755,753	0	0	0	16.00
17.00	Leasehold improvements	28,493,324	0	0	0	17.00
18.00	Accumulated depreciation	-5,525,489	0	0	0	18.00
19.00	Fixed equipment	1,460,605	0	0	0	19.00
20.00	Accumulated depreciation	-399,644	0	0	0	20.00
21.00	Automobiles and trucks	23,540	0	0	0	21.00
22.00	Accumulated depreciation	-18,022	0	0	0	22.00
23.00	Major movable equipment	37,468,810	0	0	0	23.00
24.00	Accumulated depreciation	-17,355,509	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	428,658	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	257,170,978	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,400,469	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	-581,472	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	818,997	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	313,049,380	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,843,432	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,781,792	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	40,375,919	0	0	0	43.00
44.00	Other current liabilities	18,994,211	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	70,995,354	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	7,754,123	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,754,123	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	78,749,477	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	234,299,903	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	234,299,903	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	313,049,380	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet G-1

Date/Time Prepared:
11/29/2015 9:34 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		257,242,746		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		42,424,173			2.00
3.00	Total (sum of line 1 and line 2)		299,666,919		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)		299,666,919		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00	TRANSFERS	65,367,016		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)		65,367,016		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		234,299,903		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	TRANSFERS		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2015 9:34 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	161,809,532		161,809,532	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	161,809,532		161,809,532	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	21,979,711		21,979,711	11.00
11.01	NEONATAL NICU	31,482,521		31,482,521	11.01
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	53,462,232		53,462,232	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	215,271,764		215,271,764	17.00
18.00	Ancillary services	549,030,572	716,058,661	1,265,089,233	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER PATIENT REVENUES & CAPITATION	0	1,300,003	1,300,003	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	764,302,336	717,358,664	1,481,661,000	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		310,377,749		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00		0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		310,377,749		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140290

Period:
From 07/01/2014
To 06/30/2015

Worksheet G-3

Date/Time Prepared:
11/29/2015 9:34 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,481,661,000	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,136,644,000	2.00
3.00	Net patient revenues (line 1 minus line 2)	345,017,000	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	310,377,749	4.00
5.00	Net income from service to patients (line 3 minus line 4)	34,639,251	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,508,796	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	38,808	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	297,952	20.00
21.00	Rental of vending machines	14,749	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEANINGFUL USE	1,879,783	24.00
24.01	POB RENT	1,581,963	24.01
24.02	FOUNDATION RESTRICTED FUNDS	165,027	24.02
24.03	INCOME FROM EASEMENT	-26,504	24.03
24.04	SURGICENTER JV	1,096,611	24.04
24.05	INTERCOMPANY RENT	602,874	24.05
24.06	STARBUCKS	0	24.06
24.07	INTERCOMPANY LAB	23,183	24.07
24.08	MISCELLANEOUS INCOME	601,680	24.08
25.00	Total other income (sum of lines 6-24)	7,784,922	25.00
26.00	Total (line 5 plus line 25)	42,424,173	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)	42,424,173	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140290	Period: From 07/01/2014 To 06/30/2015	Worksheet L Parts I-III Date/Time Prepared: 11/29/2015 9:34 pm
		Title XVII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,571,924	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		197,933	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)		208.63	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.42	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		24.72	8.00
9.00	Sum of lines 7 and 8		27.14	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.65	10.00
11.00	Disproportionate share adjustment (see instructions)		201,814	11.00
12.00	Total prospective capital payments (see instructions)		3,971,671	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