

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: 140304

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

Worksheet 5
Parts I-III
Date/Time Prepared:
5/18/2016 8:54 am

PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 5/18/2016 Time: 8:54 am
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.
 Contractor use only 5. Cost Report Status 6. Date Received:
 (1) As Submitted 7. Contractor No.
 (2) Settled without Audit 8. Initial Report for this Provider CCN
 (3) Settled with Audit 9. Final Report for this Provider CCN
 (4) Reopened
 (5) Amended
 10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. 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 ADVENTIST BOLINGBROOK HOSPITAL (140304) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/18/2016 Time: 8:54 am
 4i9eh0I1EwpKbdOXKjNwur66b:ejT0
 nWC.0Bq9iwy9LCyad6kbnxFKG592i
 vS7.15diB50DK5wa
 PI: Date: 5/18/2016 Time: 8:54 am
 BCWSLCC9bbKR1ph:RROAXw41m:jY00
 LFXEB0b4DM8WpuIla4EHx06w01VoiV
 EgIY0C0PU40eoFu2

(signed)

Rebecca Mathis
 Officer or Administrator of Provider(s)

VICE PRESIDENT/CFO

Title

05/23/2016

Date

	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	-69,228	-13,874	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
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	-69,228	-13,874	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140304	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/18/2016 8:49 am
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		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 500 REMINGTON BLVD	PO Box:							1.00	
2.00	City: BOLINGBROOK	State: IL	Zip Code: 60440-	County: WILL					2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ADVENTIST BOLINGBROOK HOSPITAL	140304	16974	1	01/13/2008	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2015	12/31/2015		20.00	
21.00	Type of Control (see instructions)						1		21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		N	23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	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.	1,619	924	4	37	3,435	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: 140304	Period: From 01/01/2015 To 12/31/2015	Worksheet 5-2 Part I Date/Time Prepared: 5/18/2016 8:49 am		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0			37.00	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.				38.00	
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N	40.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	Y	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete wkst. L, Pt. III and wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete wkst. D-5.	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
61.01	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		
61.02	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		
61.03	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		
61.04	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		
61.05	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		
61.06	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		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140304

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

Worksheet S-2
Part I
Date/Time Prepared:
5/18/2016 8:49 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140304	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/18/2016 8:49 am		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	0.00	0.00	0.000000		67.00
		1.00	2.00	3.00	4.00	5.00
		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0		76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N		87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N		N	94.00

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			V 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00	
Rural Providers							
105.00	Does this hospital qualify as a critical access hospital (CAH)?		N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete wkst. D-2, Pt. II.					107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N			108.00	
			Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N	N	109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.					N	110.00
						1.00 2.00 3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.		N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2				118.00
				Premiums	Losses	Insurance	
			1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:		1,675,360	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

		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	HF8013			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: ADVENTIST HEALTH SYSTEM	Contractor's Name: FIRST COAST SERVICE OPTIONS		Contractor's Number: 09001		141.00
142.00	Street: 900 HOPE WAY	PO Box:				142.00
143.00	City: ALTAMONTE SPRINGS	State: FL	Zip Code:	32714		143.00
					1.00	
144.00	Are provider based physicians' costs included in worksheet A?		Y			144.00
				1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00
					1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N			147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N			148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N			149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	
Multicampus						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00
						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)					168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				9.99	169.00
				Beginning	Ending	
				1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2014	09/30/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140304	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/18/2016 8:49 am
			1.00
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)	N		171.00

		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
Description		Y/N	Date	Y/N
0		1.00	2.00	3.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/01/2016	Y
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
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
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

	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	2.00	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	were new leases and/or amendmets to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	were home office costs claimed on the cost report?	Y			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N			40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MIKE	THOMPSON		41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVENTIST HEALTH SYSTEM SUNBELT			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	407-357-2338	MIKE.THOMPSON3@AHSS.ORG		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)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/01/2016	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER	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

Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	I/P Days / O/P	Title V
	Line Number		Available		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	122	44,530	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)		122	44,530	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		134	48,910	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)		134				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)		6	2,190			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,282	692	17,153			1.00
2.00 HMO and other (see instructions)	2,027	4,400				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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,282	692	17,153			7.00
8.00 INTENSIVE CARE UNIT	938	164	2,490			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		731	2,458			13.00
14.00 Total (see instructions)	7,220	1,587	22,101	0.00	514.83	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	32			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	514.83	27.00
28.00 Observation Bed Days		0	3,576			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	32	158			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

Component	Full Time Equivalents	Discharges				Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX			
	11.00	12.00	13.00	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,762	597	6,665	1.00	
2.00 HMO and other (see instructions)			482	1,333		2.00	
3.00 HMO IPF Subprovider				0		3.00	
4.00 HMO IRF Subprovider				0		4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00	
6.00 Hospital Adults & Peds. Swing Bed NF						6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00	
8.00 INTENSIVE CARE UNIT						8.00	
9.00 CORONARY CARE UNIT						9.00	
10.00 BURN INTENSIVE CARE UNIT						10.00	
11.00 SURGICAL INTENSIVE CARE UNIT						11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00	
13.00 NURSERY						13.00	
14.00 Total (see instructions)	0.00	0	1,762	597	6,665	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	

Provider CCN: 140304
Period: From 01/01/2015 To 12/31/2015
Worksheet S-3 Part II
Date/Time Prepared: 5/18/2016 8:49 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	35,071,621	4,376,011	39,447,632	1,221,189.00	32.30 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		100,172	0	100,172	1,292.00	77.53 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		880,471	0	880,471	11,568.00	76.11 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		449,068	0	449,068	16,517.00	27.19 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		439,905	0	439,905	11,649.00	37.76 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		110,498	0	110,498	1,138.00	97.10 13.00
14.00	Home office salaries & wage-related costs		5,918,133	0	5,918,133	77,754.00	76.11 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)		7,296,684	0	7,296,684		
18.00	wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		409,299	0	409,299		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		7,884	0	7,884		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	468,072	127,818	595,890	23,617.00	25.23 26.00
27.00	Administrative & General	5.00	3,071,577	2,806,539	5,878,116	168,437.00	34.90 27.00
28.00	Administrative & General under contract (see inst.)		29,049	0	29,049	167.00	173.95 28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00 29.00
30.00	Operation of Plant	7.00	1,443,068	124,640	1,567,708	63,691.00	24.61 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)		1,700,905	0	1,700,905	71,106.00	23.92 33.00
34.00	Dietary	10.00	5,156	-3,967	1,189	29.00	41.00 34.00
35.00	Dietary under contract (see instructions)		1,207,262	0	1,207,262	66,977.00	18.03 35.00
36.00	Cafeteria	11.00	0	3,967	3,967	97.00	40.90 36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00 37.00
38.00	Nursing Administration	13.00	567,407	462,994	1,030,401	21,265.00	48.46 38.00
39.00	Central Services and supply	14.00	437,791	61,811	499,602	23,542.00	21.22 39.00
40.00	Pharmacy	15.00	1,235,040	0	1,235,040	29,903.00	41.30 40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140304

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

Worksheet S-3
Part II
Date/Time Prepared:
5/18/2016 8:49 am

	Worksheet A Line Number	Amount Reported	Reclassificati 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	16.00 360,143	714,021	1,074,164	41,877.00	25.65	41.00
42.00	Social Service	17.00 829,505	0	829,505	22,537.00	36.81	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140304

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

Worksheet S-3
Part III
Date/Time Prepared:
5/18/2016 8:49 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	37,028,194	4,376,011	41,404,205	1,346,579.00	30.75	1.00
2.00	Excluded area salaries (see instructions)	449,068	0	449,068	16,517.00	27.19	2.00
3.00	Subtotal salaries (line 1 minus line 2)	36,579,126	4,376,011	40,955,137	1,330,062.00	30.79	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,468,536	0	6,468,536	90,541.00	71.44	4.00
5.00	Subtotal wage-related costs (see inst.)	7,296,684	0	7,296,684	0.00	17.82	5.00
6.00	Total (sum of lines 3 thru 5)	50,344,346	4,376,011	54,720,357	1,420,603.00	38.52	6.00
7.00	Total overhead cost (see instructions)	11,354,975	4,297,823	15,652,798	533,245.00	29.35	7.00

Provider CCN: 140304

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

Worksheet S-3
Part IV
Date/Time Prepared:
5/18/2016 8:49 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401k Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	865,841	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401k/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	3,858,446	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	71,175	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)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'workers' Compensation Insurance	217,603	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	2,595,600	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	-2,472	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	107,674	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,713,867	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140304

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

Worksheet S-3
Part V
Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	439,905	0	1.00
2.00	Hospital	439,905	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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 140304

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

Worksheet S-10

Date/Time Prepared:
5/18/2016 8:49 am

		1.00	
Uncompensated and indigent care cost computation			
1.00	Cost to charge ratio (worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.205820	1.00
Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid	12,582,110	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	103,252,263	6.00
7.00	Medicaid cost (line 1 times line 6)	21,251,381	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)	8,669,271	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)	3,375	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	695	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)	695	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	16,529	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	8,669,966	19.00
		Uninsured patients	Insured patients
		1.00	2.00
		Total (col. 1 + col. 2)	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	7,750,475	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,595,203	0
22.00	Partial payment by patients approved for charity care	10,804	0
23.00	Cost of charity care (line 21 minus line 22)	1,584,399	0
		1.00	3.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	7,759,405	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	478,935	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	7,280,470	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,498,466	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,082,865	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	11,752,831	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140304

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

worksheet A

Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		0	0	6,317,855	6,317,855	1.00
2.00	00200		0	0	5,712,775	5,712,775	2.00
4.00	00400	468,072	4,925,087	5,393,159	803,143	6,196,302	4.00
5.00	00500	3,071,577	22,456,882	25,528,459	-3,360,157	22,168,302	5.00
7.00	00700	1,443,068	3,840,080	5,283,148	150,522	5,433,670	7.00
9.00	00900	0	2,552,572	2,552,572	-2,670	2,549,902	9.00
10.00	01000	5,156	1,680,992	1,686,148	-1,298,651	387,497	10.00
11.00	01100	0	0	0	1,298,291	1,298,291	11.00
13.00	01300	567,407	128,079	695,486	586,866	1,282,352	13.00
14.00	01400	437,791	77,140	514,931	266,472	781,403	14.00
15.00	01500	1,235,040	5,711,190	6,946,230	-3,748,280	3,197,950	15.00
16.00	01600	360,143	147,485	507,628	924,493	1,432,121	16.00
17.00	01700	829,505	199,474	1,028,979	-130	1,028,849	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	8,193,673	1,727,190	9,920,863	-1,481,288	8,439,575	30.00
31.00	03100	2,015,425	486,633	2,502,058	-25,451	2,476,607	31.00
43.00	04300	0	19,435	19,435	980,117	999,552	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,333,329	2,488,290	5,821,619	-160,956	5,660,663	50.00
51.00	05100	532,102	63,927	596,029	0	596,029	51.00
52.00	05200	1,136,583	253,477	1,390,060	460,250	1,850,310	52.00
53.00	05300	47,723	238,036	285,759	-1,320	284,439	53.00
54.00	05400	2,482,675	1,058,370	3,541,045	-423,783	3,117,262	54.00
56.00	05600	198,382	40,832	239,214	0	239,214	56.00
57.00	05700	491,160	323,862	815,022	-180	814,842	57.00
58.00	05800	228,401	130,558	358,959	-600	358,359	58.00
59.00	05900	510,345	222,512	732,857	-2,640	730,217	59.00
60.00	06000	1,686,984	2,164,587	3,851,571	22,066	3,873,637	60.00
65.00	06500	673,453	265,667	939,120	-14,383	924,737	65.00
66.00	06600	222	4,205,222	4,205,444	-394,782	3,810,662	66.00
67.00	06700	0	197,784	197,784	-180	197,604	67.00
68.00	06800	0	36,935	36,935	-120	36,815	68.00
69.00	06900	475,625	192,486	668,111	-845	667,266	69.00
70.00	07000	35,068	406,362	441,430	-120	441,310	70.00
71.00	07100	0	2,727,404	2,727,404	445	2,727,849	71.00
72.00	07200	0	5,415,422	5,415,422	0	5,415,422	72.00
73.00	07300	0	128,689	128,689	3,527,632	3,656,321	73.00
74.00	07400	0	332,794	332,794	0	332,794	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03950	3,069	680,987	684,056	0	684,056	76.01
76.97	07697	125,788	14,311	140,099	0	140,099	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	595,358	975,383	1,570,741	-103,306	1,467,435	90.00
91.00	09100	3,439,429	1,198,666	4,638,095	-400	4,637,695	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		10,830,134	10,830,134	-10,030,685	799,449	113.00
118.00		34,622,553	78,544,936	113,167,489	0	113,167,489	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	69,143	33,600	102,743	0	102,743	190.00
192.00	19200	0	4,470,107	4,470,107	0	4,470,107	192.00
194.00	07950	138,922	19,568	158,490	0	158,490	194.00
194.01	07951	69,638	344,465	414,103	0	414,103	194.01
194.02	07952	0	79,486	79,486	0	79,486	194.02
194.03	07953	171,365	167,127	338,492	0	338,492	194.03
200.00		35,071,621	83,659,289	118,730,910	0	118,730,910	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140304

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

Worksheet A

Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	36,216	6,354,071	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	410,486	6,123,261	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-976,674	5,219,628	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-8,270,867	13,897,435	5.00
7.00	00700 OPERATION OF PLANT	-55,892	5,377,778	7.00
9.00	00900 HOUSEKEEPING	0	2,549,902	9.00
10.00	01000 DIETARY	-173,865	213,632	10.00
11.00	01100 CAFETERIA	0	1,298,291	11.00
13.00	01300 NURSING ADMINISTRATION	0	1,282,352	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	781,403	14.00
15.00	01500 PHARMACY	-13,866	3,184,084	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	38,912	1,471,033	16.00
17.00	01700 SOCIAL SERVICE	-62,667	966,182	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-405,336	8,034,239	30.00
31.00	03100 INTENSIVE CARE UNIT	-45,445	2,431,162	31.00
43.00	04300 NURSERY	0	999,552	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-684,444	4,976,219	50.00
51.00	05100 RECOVERY ROOM	0	596,029	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,850,310	52.00
53.00	05300 ANESTHESIOLOGY	0	284,439	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-13,660	3,103,602	54.00
56.00	05600 RADIOISOTOPE	0	239,214	56.00
57.00	05700 CT SCAN	0	814,842	57.00
58.00	05800 MRI	0	358,359	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	730,217	59.00
60.00	06000 LABORATORY	-21	3,873,616	60.00
65.00	06500 RESPIRATORY THERAPY	-845	923,892	65.00
66.00	06600 PHYSICAL THERAPY	0	3,810,662	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	197,604	67.00
68.00	06800 SPEECH PATHOLOGY	0	36,815	68.00
69.00	06900 ELECTROCARDIOLOGY	-117,846	549,420	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	-70,750	370,560	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-483,836	2,244,013	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	5,415,422	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-7,799	3,648,522	73.00
74.00	07400 RENAL DIALYSIS	0	332,794	74.00
76.00	03020 ANCILLARY	0	0	76.00
76.01	03950 WOUND CARE	-442	683,614	76.01
76.97	07697 CARDIAC REHABILITATION	-9,569	130,530	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	-743,787	723,648	90.00
91.00	09100 EMERGENCY	-478,687	4,159,008	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE	-799,449	0	113.00
118.00	11800 SUBTOTALS (SUM OF LINES 1-117)	-12,930,133	100,237,356	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	102,743	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	4,470,107	192.00
194.00	07950 FOUNDATION	0	158,490	194.00
194.01	07951 MARKETING	0	414,103	194.01
194.02	07952 PROF OFFICE BUILDINGS	0	79,486	194.02
194.03	07953 OP PHARMACY	0	338,492	194.03
200.00	TOTAL (SUM OF LINES 118-199)	-12,930,133	105,800,777	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	3,967	1,294,324	1.00
	0		3,967	1,294,324	
B - NURSERY					
1.00	NURSERY	43.00	778,768	201,349	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	310,091	156,660	2.00
	0		1,088,859	358,009	
C - PROPERTY					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	66,618	1.00
	0		0	66,618	
D - CNO					
1.00	NURSING ADMINISTRATION	13.00	234,700	105,380	1.00
	0		234,700	105,380	
E - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,505,348	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,257,901	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	347,388	3.00
	0		0	3,110,637	
F - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,624,739	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,834,124	2.00
	0		0	7,458,863	
G - SHARED SERVICES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	127,818	675,325	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	3,041,239	2,434,896	2.00
3.00	OPERATION OF PLANT	7.00	124,640	26,962	3.00
4.00	NURSING ADMINISTRATION	13.00	228,294	18,932	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	61,811	205,386	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	714,021	210,592	6.00
7.00	LABORATORY	60.00	78,188	90,860	7.00
8.00	ADMINISTRATIVE & GENERAL	5.00	4,376,011	0	8.00
	0		8,752,022	3,662,953	
H - BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	445	1.00
	0		0	445	
I - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,527,632	1.00
2.00		0.00	0	0	2.00
	0		0	3,527,632	
J - RENT AND LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	938,271	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	618,750	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
	0		0	1,557,021	
K - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	182,879	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,000	2.00
	0		0	184,879	
500.00	Grand Total: Increases		10,079,548	21,326,761	500.00

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - CAFETERIA						
1.00	DIETARY	10.00	3,967	1,294,324	0	1.00
	0		3,967	1,294,324		
B - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	1,088,859	358,009	0	1.00
2.00		0.00	0	0	0	2.00
	0		1,088,859	358,009		
C - PROPERTY						
1.00	INTEREST EXPENSE	113.00	0	66,618	13	1.00
	0		0	66,618		
D - CNO						
1.00	ADMINISTRATIVE & GENERAL	5.00	234,700	105,380	0	1.00
	0		234,700	105,380		
E - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	3,110,637	11	1.00
2.00		0.00	0	0	11	2.00
3.00		0.00	0	0	0	3.00
	0		0	3,110,637		
F - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	605,433	9	1.00
2.00	INTEREST EXPENSE	113.00	0	6,853,430	9	2.00
	0		0	7,458,863		
G - SHARED SERVICES						
1.00	ADMINISTRATIVE & GENERAL	5.00	4,376,011	3,662,953	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	4,376,011	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
	0		4,376,011	8,038,964		
H - BILLABLE SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	445	0	1.00
	0		0	445		
I - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	3,527,385	0	1.00
2.00	OPERATING ROOM	50.00	0	247	0	2.00
	0		0	3,527,632		
J - RENT AND LEASES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,324	10	1.00
2.00	OPERATION OF PLANT	7.00	0	1,080	10	2.00
3.00	HOUSEKEEPING	9.00	0	2,670	0	3.00
4.00	DIETARY	10.00	0	360	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	440	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	280	0	6.00
7.00	PHARMACY	15.00	0	220,895	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	120	0	8.00
9.00	SOCIAL SERVICE	17.00	0	130	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	34,420	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	25,451	0	11.00
12.00	OPERATING ROOM	50.00	0	160,709	0	12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	6,501	0	13.00
14.00	ANESTHESIOLOGY	53.00	0	1,320	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	423,783	0	15.00
16.00	CT SCAN	57.00	0	180	0	16.00
17.00	MRI	58.00	0	600	0	17.00
18.00	CARDIAC CATHETERIZATION	59.00	0	2,640	0	18.00
19.00	LABORATORY	60.00	0	146,982	0	19.00
20.00	RESPIRATORY THERAPY	65.00	0	14,383	0	20.00
21.00	PHYSICAL THERAPY	66.00	0	394,782	0	21.00
22.00	OCCUPATIONAL THERAPY	67.00	0	180	0	22.00
23.00	SPEECH PATHOLOGY	68.00	0	120	0	23.00
24.00	ELECTROCARDIOLOGY	69.00	0	845	0	24.00
25.00	ELECTROENCEPHALOGRAPHY	70.00	0	120	0	25.00
26.00	CLINIC	90.00	0	103,306	0	26.00
27.00	EMERGENCY	91.00	0	400	0	27.00
	0		0	1,557,021		
K - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	184,879	12	1.00
2.00		0.00	0	0	12	2.00
	0		0	184,879		
500.00	Grand Total: Decreases		5,703,537	25,702,772		500.00

		Beginning Balances 1.00	Acquisitions			Disposals and Retirements 5.00	
			Purchases 2.00	Donation 3.00	Total 4.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,440,226	0	0	0	0	1.00
2.00	Land Improvements	84,552	0	0	0	0	2.00
3.00	Buildings and Fixtures	107,081,097	3,210,380	0	3,210,380	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	22,856,209	84,225	0	84,225	0	5.00
6.00	Movable Equipment	38,116,164	961,287	0	961,287	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	173,578,248	4,255,892	0	4,255,892	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	173,578,248	4,255,892	0	4,255,892	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,440,226	0				1.00
2.00	Land Improvements	84,552	0				2.00
3.00	Buildings and Fixtures	110,291,477	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	22,940,434	0				5.00
6.00	Movable Equipment	39,077,451	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	177,834,140	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	177,834,140	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140304

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

Worksheet A-7
Part II
Date/Time Prepared:
5/18/2016 8:49 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140304

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

Worksheet A-7
Part III
Date/Time Prepared:
5/18/2016 8:49 am

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	138,756,690	0	138,756,690	0.780259	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	39,077,451	0	39,077,451	0.219741	0	2.00
3.00	Total (sum of lines 1-2)	177,834,141	0	177,834,141	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	3,727,573	938,271	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,244,610	618,750	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,972,183	1,557,021	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	1,505,348	182,879	0	0	6,354,071	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,257,901	2,000	0	0	6,123,261	2.00
3.00	Total (sum of lines 1-2)	2,763,249	184,879	0	0	12,477,332	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)		0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-23,018	ADMINISTRATIVE & GENERAL	5.00		0	7.00
8.00 Television and radio service (chapter 21)	A	-19,367	OPERATION OF PLANT	7.00		0	8.00
9.00 Parking lot (chapter 21)		0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,733,401				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	1,181,036				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-173,865	DIETARY	10.00		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	-9,486	MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00		0	19.00
20.00 Vending machines		0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant		0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	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 OTHER REVENUE	B	-177,865	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.00
33.01 OTHER REVENUE	B	-2,314,210	ADMINISTRATIVE & GENERAL	5.00		0	33.01

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			wkst. A-7	Ref.
			Cost Center		Line #		
			1.00	2.00	3.00		
33.02 OTHER REVENUE	B	-36,525	OPERATION OF PLANT		7.00	0	33.02
33.03 OTHER REVENUE	B	-4,623	EMERGENCY		91.00	0	33.03
33.06 OTHER REVENUE	B	-8,785	ADULTS & PEDIATRICS		30.00	0	33.06
33.07 OTHER REVENUE	B	-102,225	OPERATING ROOM		50.00	0	33.07
33.08 OTHER REVENUE	B	-5,455	RADIOLOGY-DIAGNOSTIC		54.00	0	33.08
33.09 OTHER REVENUE	B	-1,918	DRUGS CHARGED TO PATIENTS		73.00	0	33.09
33.10 OTHER REVENUE	B	-9,569	CARDIAC REHABILITATION		76.97	0	33.10
33.11 OTHER REVENUE	B	-10,802	CLINIC		90.00	0	33.11
33.12 SELF INSURANCE ADJUSTMENT	A	-1,077,225	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.12
33.13 PHYSICIAN COLLECTION FEES	A	-41,690	ELECTROCARDIOLOGY		69.00	0	33.13
33.14 PHYSICIAN COLLECTION FEES	A	-24,783	CLINIC		90.00	0	33.14
33.15 LOBBYING	A	-30,679	ADMINISTRATIVE & GENERAL		5.00	0	33.15
33.16 ADVERTISING	A	-3,705	RADIOLOGY-DIAGNOSTIC		54.00	0	33.16
33.17 ADVERTISING	A	-442	WOUND CARE		76.01	0	33.17
33.18 LEGAL	A	-251,692	ADMINISTRATIVE & GENERAL		5.00	0	33.18
33.19 PROPERTY TAXES	A	-66,618	CAP REL COSTS-BLDG & FIXT		1.00	13	33.19
33.20 STATE ASSESSMENT TAX	A	-4,643,504	ADMINISTRATIVE & GENERAL		5.00	0	33.20
33.21 SPECIAL ADMIN	A	-109,161	ADMINISTRATIVE & GENERAL		5.00	0	33.21
33.22 NON ALLOW PHYSICIAN FEE	A	-445,100	ADMINISTRATIVE & GENERAL		5.00	0	33.22
33.23 NON ALLOW PHYSICIAN FEE	A	-62,667	SOCIAL SERVICE		17.00	0	33.23
33.24 MALPRACTICE	A	-1,675,360	ADMINISTRATIVE & GENERAL		5.00	0	33.24
33.25 SPECIAL EVENTS	A	2,260	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.25
33.26 SPECIAL EVENTS	A	-10,141	ADMINISTRATIVE & GENERAL		5.00	0	33.26
33.27 HOSPICE	A	-845	RESPIRATORY THERAPY		65.00	0	33.27
33.28 HOSPICE	A	-5,881	DRUGS CHARGED TO PATIENTS		73.00	0	33.28
33.29 HOSPICE	A	-21	LABORATORY		60.00	0	33.29
33.30 HOSPICE	A	-29,726	ADULTS & PEDIATRICS		30.00	0	33.30
33.31 HOSPICE	A	-3,075	INTENSIVE CARE UNIT		31.00	0	33.31
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-12,930,133					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: 140304

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

Worksheet A-8-1

Date/Time Prepared: 5/18/2016 8:49 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	AHS SHARED SERVICES	8,038,965	6,999,698 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	AHS HOME OFFICE	102,834	0 2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	AHS HOME OFFICE	410,486	0 3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	AHS HOME OFFICE	295,090	17,929 3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	AHS HOME OFFICE	6,760,388	6,117,977 3.02
4.00	15.00	PHARMACY	AHS HOME OFFICE	0	13,866 4.00
4.01	31.00	INTENSIVE CARE UNIT	AHS HOME OFFICE	0	42,370 4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	AHS HOME OFFICE	48,398	0 4.02
4.03	71.00	MEDICAL SUPPLIES CHARGED TO	AHS HOME OFFICE	-483,836	0 4.03
4.05	113.00	INTEREST EXPENSE	AHS HOME OFFICE	3,110,637	3,910,086 4.05
5.00	TOTALS (sum of lines 1-4).			18,282,962	17,101,926 5.00
Transfer column 6, line 5 to worksheet A-8, column 2, line 12.					

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

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

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

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

6.00	B	AHS	100.00	HOME OFFICE	0.00	6.00
7.00	B	HINSDALE HOSPIT	0.00	RELATED PARTY	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 140304

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

worksheet A-8-1

Date/Time Prepared:
5/18/2016 8:49 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,039,267	0	1.00
2.00	102,834	9	2.00
3.00	410,486	9	3.00
3.01	277,161	0	3.01
3.02	642,411	0	3.02
4.00	-13,866	0	4.00
4.01	-42,370	0	4.01
4.02	48,398	0	4.02
4.03	-483,836	0	4.03
4.05	-799,449	0	4.05
5.00	1,181,036		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	MANAGEMENT SERVICES	6.00
7.00	FINANCIAL SERVICES	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: 140304

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

Worksheet A-8-2

Date/Time Prepared:
5/18/2016 8:49 am

	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours		
1.00	91.00	AGGREGATE-EMERGENCY	100,613	100,613	0	0	0	1.00
2.00	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTME	1,005	1,005	0	0	0	2.00
3.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	449,680	449,680	0	0	0	3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	366,825	366,825	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	582,219	582,219	0	0	0	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	4,500	4,500	0	0	0	6.00
7.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	76,156	76,156	0	0	0	7.00
8.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	70,750	70,750	0	0	0	8.00
9.00	90.00	AGGREGATE-CLINIC	708,202	708,202	0	0	0	9.00
10.00	91.00	AGGREGATE-EMERGENCY	373,451	373,451	0	0	0	10.00
200.00			2,733,401	2,733,401	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	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	1.00
2.00	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTME	0	0	0	0	0	2.00
3.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	0	0	0	8.00
9.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	9.00
10.00	91.00	AGGREGATE-EMERGENCY	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	91.00	AGGREGATE-EMERGENCY	0	0	0	100,613		1.00
2.00	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTME	0	0	0	1,005		2.00
3.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	449,680		3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	366,825		4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	582,219		5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	4,500		6.00
7.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	76,156		7.00
8.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	0	70,750		8.00
9.00	90.00	AGGREGATE-CLINIC	0	0	0	708,202		9.00
10.00	91.00	AGGREGATE-EMERGENCY	0	0	0	373,451		10.00
200.00			0	0	0	2,733,401		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140304

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

Worksheet B
Part I
Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	6,354,071	6,354,071			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	6,123,261		6,123,261		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,219,628	2,449	2,360	5,224,437	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	13,897,435	202,386	195,034	790,436	15,085,291 5.00
7.00 00700	OPERATION OF PLANT	5,377,778	423,221	407,847	210,811	6,419,657 7.00
9.00 00900	HOUSEKEEPING	2,549,902	38,765	37,357	0	2,626,024 9.00
10.00 01000	DIETARY	213,632	203,972	196,562	160	614,326 10.00
11.00 01100	CAFETERIA	1,298,291	76,061	73,298	533	1,448,183 11.00
13.00 01300	NURSING ADMINISTRATION	1,282,352	127,025	122,410	138,559	1,670,346 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	781,403	134,652	129,760	67,182	1,112,997 14.00
15.00 01500	PHARMACY	3,184,084	53,343	51,405	166,077	3,454,909 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,471,033	79,326	76,445	144,444	1,771,248 16.00
17.00 01700	SOCIAL SERVICE	966,182	16,817	16,206	111,544	1,110,749 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	8,034,239	1,791,450	1,726,378	955,396	12,507,463 30.00
31.00 03100	INTENSIVE CARE UNIT	2,431,162	275,764	265,747	271,016	3,243,689 31.00
43.00 04300	NURSERY	999,552	83,968	80,918	104,722	1,269,160 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	4,976,219	774,136	746,015	448,236	6,944,606 50.00
51.00 05100	RECOVERY ROOM	596,029	82,941	79,929	71,552	830,451 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,850,310	295,683	284,942	194,536	2,625,471 52.00
53.00 05300	ANESTHESIOLOGY	284,439	14,531	14,003	6,417	319,390 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,103,602	538,186	518,637	333,848	4,494,273 54.00
56.00 05600	RADIOISOTOPE	239,214	170,361	164,173	26,677	600,425 56.00
57.00 05700	CT SCAN	814,842	30,508	29,400	66,047	940,797 57.00
58.00 05800	MRI	358,359	21,458	20,679	30,713	431,209 58.00
59.00 05900	CARDIAC CATHETERIZATION	730,217	26,240	25,287	68,627	850,371 59.00
60.00 06000	LABORATORY	3,873,616	92,528	89,167	237,364	4,292,675 60.00
65.00 06500	RESPIRATORY THERAPY	923,892	12,595	12,138	90,560	1,039,185 65.00
66.00 06600	PHYSICAL THERAPY	3,810,662	148,739	143,337	30	4,102,768 66.00
67.00 06700	OCCUPATIONAL THERAPY	197,604	22,251	21,443	0	241,298 67.00
68.00 06800	SPEECH PATHOLOGY	36,815	1,959	1,888	0	40,662 68.00
69.00 06900	ELECTROCARDIOLOGY	549,420	13,691	13,194	63,958	640,263 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	370,560	32,188	31,018	4,716	438,482 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,244,013	0	0	0	2,244,013 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,415,422	0	0	0	5,415,422 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	3,648,522	0	0	0	3,648,522 73.00
74.00 07400	RENAL DIALYSIS	332,794	0	0	0	332,794 74.00
76.00 03020	ANCILLARY	0	0	0	0	0 76.00
76.01 03950	WOUND CARE	683,614	60,643	58,441	413	803,111 76.01
76.97 07697	CARDIAC REHABILITATION	130,530	35,220	33,940	16,915	216,605 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	723,648	84,504	81,435	80,058	969,645 90.00
91.00 09100	EMERGENCY	4,159,008	341,749	329,335	462,503	5,292,595 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	100,237,356	6,309,310	6,080,128	5,164,050	100,089,075 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	102,743	25,494	24,567	9,298	162,102 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	4,470,107	0	0	0	4,470,107 192.00
194.00 07950	FOUNDATION	158,490	4,712	4,540	18,681	186,423 194.00
194.01 07951	MARKETING	414,103	9,097	8,766	9,364	441,330 194.01
194.02 07952	PROF OFFICE BUILDINGS	79,486	0	0	0	79,486 194.02
194.03 07953	OP PHARMACY	338,492	5,458	5,260	23,044	372,254 194.03
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers					0 201.00
202.00	TOTAL (sum lines 118-201)	105,800,777	6,354,071	6,123,261	5,224,437	105,800,777 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140304

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

Worksheet B
Part I
Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.00	7.00	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	15,085,291				5.00
7.00	00700	OPERATION OF PLANT	1,067,538	7,487,195			7.00
9.00	00900	HOUSEKEEPING	436,687	50,688	3,113,399		9.00
10.00	01000	DIETARY	102,157	266,708	111,661	1,094,852	10.00
11.00	01100	CAFETERIA	240,821	99,455	41,638	0	1,830,097
13.00	01300	NURSING ADMINISTRATION	277,765	166,094	69,538	0	31,727
14.00	01400	CENTRAL SERVICES & SUPPLY	185,082	176,067	73,713	0	41,608
15.00	01500	PHARMACY	574,524	69,750	29,202	0	60,101
16.00	01600	MEDICAL RECORDS & LIBRARY	294,544	103,725	43,426	0	32,091
17.00	01700	SOCIAL SERVICE	184,709	21,989	9,206	0	45,210
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,079,922	2,342,456	980,701	956,059	487,291
31.00	03100	INTENSIVE CARE UNIT	539,400	360,582	150,963	138,793	102,505
43.00	04300	NURSERY	211,051	109,794	45,967	0	46,225
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,154,832	1,012,241	423,789	0	191,875
51.00	05100	RECOVERY ROOM	138,097	108,452	45,405	0	22,978
52.00	05200	DELIVERY ROOM & LABOR ROOM	436,595	386,628	161,867	0	79,613
53.00	05300	ANESTHESIOLOGY	53,112	19,000	7,955	0	4,574
54.00	05400	RADIOLOGY-DIAGNOSTIC	747,362	703,719	294,622	0	151,432
56.00	05600	RADIOISOTOPE	99,846	222,760	93,262	0	8,287
57.00	05700	CT SCAN	156,447	39,892	16,701	0	25,448
58.00	05800	MRI	71,707	28,058	11,747	0	10,933
59.00	05900	CARDIAC CATHETERIZATION	141,410	34,311	14,365	0	21,516
60.00	06000	LABORATORY	713,838	120,987	50,653	0	119,085
65.00	06500	RESPIRATORY THERAPY	172,808	16,469	6,895	0	44,902
66.00	06600	PHYSICAL THERAPY	682,257	194,488	81,425	0	15
67.00	06700	OCCUPATIONAL THERAPY	40,126	29,095	12,181	0	0
68.00	06800	SPEECH PATHOLOGY	6,762	2,562	1,073	0	0
69.00	06900	ELECTROCARDIOLOGY	106,471	17,903	7,495	0	28,710
70.00	07000	ELECTROENCEPHALOGRAPHY	72,916	42,088	17,621	0	2,503
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	373,161	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	900,541	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	606,720	0	0	0	0
74.00	07400	RENAL DIALYSIS	55,341	0	0	0	0
76.00	03020	ANCILLARY	0	0	0	0	0
76.01	03950	WOUND CARE	133,551	79,296	33,198	0	128
76.97	07697	CARDIAC REHABILITATION	36,020	46,053	19,281	0	6,812
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	161,244	110,496	46,261	0	39,953
91.00	09100	EMERGENCY	880,116	446,862	187,085	0	208,943
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)	14,135,480	7,428,668	3,088,896	1,094,852	1,814,465
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	26,956	33,335	13,956	0	3,956
192.00	19200	PHYSICIANS' PRIVATE OFFICES	743,343	0	0	0	0
194.00	07950	FOUNDATION	31,001	6,161	2,579	0	8,050
194.01	07951	MARKETING	73,390	11,894	4,980	0	3,626
194.02	07952	PROF OFFICE BUILDINGS	13,218	0	0	0	0
194.03	07953	OP PHARMACY	61,903	7,137	2,988	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	15,085,291	7,487,195	3,113,399	1,094,852	1,830,097

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140304

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

Worksheet B
Part I
Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		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
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	2,215,470					13.00
14.00	01400	0	1,589,467				14.00
15.00	01500	0	3,332	4,191,818			15.00
16.00	01600	0	0	0	2,245,034		16.00
17.00	01700	0	0	1,485	0	1,373,348	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	911,837	71,294	51	133,254	1,058,316	30.00
31.00	03100	191,811	28,302	0	25,821	153,629	31.00
43.00	04300	86,498	7,918	0	12,628	151,655	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	359,045	162,249	19,897	225,473	0	50.00
51.00	05100	42,998	3,138	0	25,230	0	51.00
52.00	05200	148,976	14,713	0	23,458	9,748	52.00
53.00	05300	8,559	17,255	85,035	58,576	0	53.00
54.00	05400	0	6,537	586	215,910	0	54.00
56.00	05600	0	547	5,333	28,118	0	56.00
57.00	05700	0	11,022	0	230,005	0	57.00
58.00	05800	0	897	0	55,993	0	58.00
59.00	05900	0	8,340	10,809	24,913	0	59.00
60.00	06000	0	8,739	27	271,097	0	60.00
65.00	06500	0	13,957	0	39,846	0	65.00
66.00	06600	0	784	347	63,485	0	66.00
67.00	06700	0	0	0	4,524	0	67.00
68.00	06800	0	0	16,558	2,234	0	68.00
69.00	06900	0	480	0	61,476	0	69.00
70.00	07000	0	553	0	15,774	0	70.00
71.00	07100	0	359,653	1,363	63,864	0	71.00
72.00	07200	0	797,221	0	94,657	0	72.00
73.00	07300	0	0	4,040,434	200,650	0	73.00
74.00	07400	0	0	0	5,573	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03950	0	3,978	8,877	12,210	0	76.01
76.97	07697	0	164	0	2,973	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	74,762	6,496	119	28,001	0	90.00
91.00	09100	390,984	61,898	897	319,291	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		2,215,470	1,589,467	4,191,818	2,245,034	1,373,348	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
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		2,215,470	1,589,467	4,191,818	2,245,034	1,373,348	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140304

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

Worksheet B
Part I
Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	21,528,644	0	21,528,644	30.00
31.00	03100	4,935,495	0	4,935,495	31.00
43.00	04300	1,940,896	0	1,940,896	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	10,494,007	0	10,494,007	50.00
51.00	05100	1,216,749	0	1,216,749	51.00
52.00	05200	3,887,069	0	3,887,069	52.00
53.00	05300	573,456	0	573,456	53.00
54.00	05400	6,614,441	0	6,614,441	54.00
56.00	05600	1,058,578	0	1,058,578	56.00
57.00	05700	1,420,312	0	1,420,312	57.00
58.00	05800	610,544	0	610,544	58.00
59.00	05900	1,106,035	0	1,106,035	59.00
60.00	06000	5,577,101	0	5,577,101	60.00
65.00	06500	1,334,062	0	1,334,062	65.00
66.00	06600	5,125,569	0	5,125,569	66.00
67.00	06700	327,224	0	327,224	67.00
68.00	06800	69,851	0	69,851	68.00
69.00	06900	862,798	0	862,798	69.00
70.00	07000	589,937	0	589,937	70.00
71.00	07100	3,042,054	0	3,042,054	71.00
72.00	07200	7,207,841	0	7,207,841	72.00
73.00	07300	8,496,326	0	8,496,326	73.00
74.00	07400	393,708	0	393,708	74.00
76.00	03020	0	0	0	76.00
76.01	03950	1,074,349	0	1,074,349	76.01
76.97	07697	327,908	0	327,908	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	1,436,977	0	1,436,977	90.00
91.00	09100	7,788,671	0	7,788,671	91.00
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		99,040,602	0	99,040,602	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	240,305	0	240,305	190.00
192.00	19200	5,213,450	0	5,213,450	192.00
194.00	07950	234,214	0	234,214	194.00
194.01	07951	535,220	0	535,220	194.01
194.02	07952	92,704	0	92,704	194.02
194.03	07953	444,282	0	444,282	194.03
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		105,800,777	0	105,800,777	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140304

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

Worksheet B
Part II
Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,449	2,360	4,809	4,809
5.00 00500	ADMINISTRATIVE & GENERAL	0	202,386	195,034	397,420	729
7.00 00700	OPERATION OF PLANT	0	423,221	407,847	831,068	194
9.00 00900	HOUSEKEEPING	0	38,765	37,357	76,122	0
10.00 01000	DIETARY	0	203,972	196,562	400,534	0
11.00 01100	CAFETERIA	0	76,061	73,298	149,359	0
13.00 01300	NURSING ADMINISTRATION	0	127,025	122,410	249,435	128
14.00 01400	CENTRAL SERVICES & SUPPLY	0	134,652	129,760	264,412	62
15.00 01500	PHARMACY	0	53,343	51,405	104,748	153
16.00 01600	MEDICAL RECORDS & LIBRARY	0	79,326	76,445	155,771	133
17.00 01700	SOCIAL SERVICE	0	16,817	16,206	33,023	103
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,791,450	1,726,378	3,517,828	873
31.00 03100	INTENSIVE CARE UNIT	0	275,764	265,747	541,511	250
43.00 04300	NURSERY	0	83,968	80,918	164,886	97
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	774,136	746,015	1,520,151	413
51.00 05100	RECOVERY ROOM	0	82,941	79,929	162,870	66
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	295,683	284,942	580,625	179
53.00 05300	ANESTHESIOLOGY	0	14,531	14,003	28,534	6
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	538,186	518,637	1,056,823	308
56.00 05600	RADIOISOTOPE	0	170,361	164,173	334,534	25
57.00 05700	CT SCAN	0	30,508	29,400	59,908	61
58.00 05800	MRI	0	21,458	20,679	42,137	28
59.00 05900	CARDIAC CATHETERIZATION	0	26,240	25,287	51,527	63
60.00 06000	LABORATORY	0	92,528	89,167	181,695	219
65.00 06500	RESPIRATORY THERAPY	0	12,595	12,138	24,733	84
66.00 06600	PHYSICAL THERAPY	0	148,739	143,337	292,076	0
67.00 06700	OCCUPATIONAL THERAPY	0	22,251	21,443	43,694	0
68.00 06800	SPEECH PATHOLOGY	0	1,959	1,888	3,847	0
69.00 06900	ELECTROCARDIOLOGY	0	13,691	13,194	26,885	59
70.00 07000	ELECTROENCEPHALOGRAPHY	0	32,188	31,018	63,206	4
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
76.00 03020	ANCILLARY	0	0	0	0	0
76.01 03950	WOUND CARE	0	60,643	58,441	119,084	0
76.97 07697	CARDIAC REHABILITATION	0	35,220	33,940	69,160	16
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	84,504	81,435	165,939	74
91.00 09100	EMERGENCY	0	341,749	329,335	671,084	426
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	6,309,310	6,080,128	12,389,438	4,753
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,494	24,567	50,061	9
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00 07950	FOUNDATION	0	4,712	4,540	9,252	17
194.01 07951	MARKETING	0	9,097	8,766	17,863	9
194.02 07952	PROF OFFICE BUILDINGS	0	0	0	0	0
194.03 07953	OP PHARMACY	0	5,458	5,260	10,718	21
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	6,354,071	6,123,261	12,477,332	4,809

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140304

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.00	7.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	398,149					5.00
7.00	00700	28,176	859,438				7.00
9.00	00900	11,526	5,818	93,466			9.00
10.00	01000	2,696	30,615	3,352	437,197		10.00
11.00	01100	6,356	11,416	1,250	0	168,381	11.00
13.00	01300	7,331	19,066	2,088	0	2,919	13.00
14.00	01400	4,885	20,210	2,213	0	3,828	14.00
15.00	01500	15,164	8,006	877	0	5,530	15.00
16.00	01600	7,774	11,906	1,304	0	2,953	16.00
17.00	01700	4,875	2,524	276	0	4,160	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	54,895	268,889	29,441	381,774	44,832	30.00
31.00	03100	14,237	41,390	4,532	55,423	9,431	31.00
43.00	04300	5,570	12,603	1,380	0	4,253	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	30,480	116,193	12,722	0	17,654	50.00
51.00	05100	3,645	12,449	1,363	0	2,114	51.00
52.00	05200	11,523	44,380	4,859	0	7,325	52.00
53.00	05300	1,402	2,181	239	0	421	53.00
54.00	05400	19,725	80,778	8,845	0	13,933	54.00
56.00	05600	2,635	25,570	2,800	0	762	56.00
57.00	05700	4,129	4,579	501	0	2,341	57.00
58.00	05800	1,893	3,221	353	0	1,006	58.00
59.00	05900	3,732	3,938	431	0	1,980	59.00
60.00	06000	18,841	13,888	1,521	0	10,957	60.00
65.00	06500	4,561	1,890	207	0	4,131	65.00
66.00	06600	18,007	22,325	2,444	0	1	66.00
67.00	06700	1,059	3,340	366	0	0	67.00
68.00	06800	178	294	32	0	0	68.00
69.00	06900	2,810	2,055	225	0	2,642	69.00
70.00	07000	1,924	4,831	529	0	230	70.00
71.00	07100	9,849	0	0	0	0	71.00
72.00	07200	23,768	0	0	0	0	72.00
73.00	07300	16,013	0	0	0	0	73.00
74.00	07400	1,461	0	0	0	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03950	3,525	9,102	997	0	12	76.01
76.97	07697	951	5,286	579	0	627	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	4,256	12,684	1,389	0	3,676	90.00
91.00	09100	23,229	51,294	5,616	0	19,224	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		373,081	852,721	92,731	437,197	166,942	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	711	3,826	419	0	364	190.00
192.00	19200	19,619	0	0	0	0	192.00
194.00	07950	818	707	77	0	741	194.00
194.01	07951	1,937	1,365	149	0	334	194.01
194.02	07952	349	0	0	0	0	194.02
194.03	07953	1,634	819	90	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		398,149	859,438	93,466	437,197	168,381	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140304

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

Worksheet B
Part II
Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		NURSING	CENTRAL	PHARMACY	MEDICAL	SOCIAL SERVICE	
		ADMINISTRATION	SERVICES & SUPPLY		RECORDS & LIBRARY		
		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
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	280,967					13.00
14.00	01400	0	295,610				14.00
15.00	01500	0	620	135,098			15.00
16.00	01600	0	0	0	179,841		16.00
17.00	01700	0	0	48	0	45,009	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	115,640	13,259	2	10,683	34,685	30.00
31.00	03100	24,326	5,264	0	2,070	5,035	31.00
43.00	04300	10,970	1,473	0	1,012	4,970	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	45,534	30,175	641	18,076	0	50.00
51.00	05100	5,453	584	0	2,023	0	51.00
52.00	05200	18,893	2,736	0	1,881	319	52.00
53.00	05300	1,085	3,209	2,741	4,696	0	53.00
54.00	05400	0	1,216	19	17,310	0	54.00
56.00	05600	0	102	172	2,254	0	56.00
57.00	05700	0	2,050	0	18,440	0	57.00
58.00	05800	0	167	0	4,489	0	58.00
59.00	05900	0	1,551	348	1,997	0	59.00
60.00	06000	0	1,625	1	21,734	0	60.00
65.00	06500	0	2,596	0	3,195	0	65.00
66.00	06600	0	146	11	5,090	0	66.00
67.00	06700	0	0	0	363	0	67.00
68.00	06800	0	0	534	179	0	68.00
69.00	06900	0	89	0	4,929	0	69.00
70.00	07000	0	103	0	1,265	0	70.00
71.00	07100	0	66,888	44	5,120	0	71.00
72.00	07200	0	148,267	0	7,589	0	72.00
73.00	07300	0	0	130,218	16,086	0	73.00
74.00	07400	0	0	0	447	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03950	0	740	286	979	0	76.01
76.97	07697	0	30	0	238	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	9,481	1,208	4	2,245	0	90.00
91.00	09100	49,585	11,512	29	25,451	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		280,967	295,610	135,098	179,841	45,009	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
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		280,967	295,610	135,098	179,841	45,009	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140304

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	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
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,472,801	0	4,472,801
31.00	03100	INTENSIVE CARE UNIT	703,469	0	703,469
43.00	04300	NURSERY	207,214	0	207,214
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,792,039	0	1,792,039
51.00	05100	RECOVERY ROOM	190,567	0	190,567
52.00	05200	DELIVERY ROOM & LABOR ROOM	672,720	0	672,720
53.00	05300	ANESTHESIOLOGY	44,514	0	44,514
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,198,957	0	1,198,957
56.00	05600	RADIOISOTOPE	368,854	0	368,854
57.00	05700	CT SCAN	92,009	0	92,009
58.00	05800	MRI	53,294	0	53,294
59.00	05900	CARDIAC CATHETERIZATION	65,567	0	65,567
60.00	06000	LABORATORY	250,481	0	250,481
65.00	06500	RESPIRATORY THERAPY	41,397	0	41,397
66.00	06600	PHYSICAL THERAPY	340,100	0	340,100
67.00	06700	OCCUPATIONAL THERAPY	48,822	0	48,822
68.00	06800	SPEECH PATHOLOGY	5,064	0	5,064
69.00	06900	ELECTROCARDIOLOGY	39,694	0	39,694
70.00	07000	ELECTROENCEPHALOGRAPHY	72,092	0	72,092
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	81,901	0	81,901
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	179,624	0	179,624
73.00	07300	DRUGS CHARGED TO PATIENTS	162,317	0	162,317
74.00	07400	RENAL DIALYSIS	1,908	0	1,908
76.00	03020	ANCILLARY	0	0	0
76.01	03950	WOUND CARE	134,725	0	134,725
76.97	07697	CARDIAC REHABILITATION	76,887	0	76,887
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	200,956	0	200,956
91.00	09100	EMERGENCY	857,450	0	857,450
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,355,423	0	12,355,423
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	55,390	0	55,390
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,619	0	19,619
194.00	07950	FOUNDATION	11,612	0	11,612
194.01	07951	MARKETING	21,657	0	21,657
194.02	07952	PROF OFFICE BUILDINGS	349	0	349
194.03	07953	OP PHARMACY	13,282	0	13,282
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118-201)	12,477,332	0	12,477,332

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140304

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

Worksheet B-1

Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
	BLDG & FIXT (SQARE FEET)	MVBLE EQUIP (SQARE FEET)					
	1.00	2.00	4.00	5A	5.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	272,422				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		272,422			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	105	105	38,851,742		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,677	8,677	5,878,116	-15,085,291	5.00
7.00	00700	OPERATION OF PLANT	18,145	18,145	1,567,708	0	7.00
9.00	00900	HOUSEKEEPING	1,662	1,662	0	0	9.00
10.00	01000	DIETARY	8,745	8,745	1,189	0	10.00
11.00	01100	CAFETERIA	3,261	3,261	3,967	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,446	5,446	1,030,401	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,773	5,773	499,602	0	14.00
15.00	01500	PHARMACY	2,287	2,287	1,235,040	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,401	3,401	1,074,164	0	16.00
17.00	01700	SOCIAL SERVICE	721	721	829,505	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	76,806	76,806	7,104,814	0	30.00
31.00	03100	INTENSIVE CARE UNIT	11,823	11,823	2,015,425	0	31.00
43.00	04300	NURSERY	3,600	3,600	778,768	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	33,190	33,190	3,333,329	0	50.00
51.00	05100	RECOVERY ROOM	3,556	3,556	532,102	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,677	12,677	1,446,674	0	52.00
53.00	05300	ANESTHESIOLOGY	623	623	47,723	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,074	23,074	2,482,675	0	54.00
56.00	05600	RADIOISOTOPE	7,304	7,304	198,382	0	56.00
57.00	05700	CT SCAN	1,308	1,308	491,160	0	57.00
58.00	05800	MRI	920	920	228,401	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,125	1,125	510,345	0	59.00
60.00	06000	LABORATORY	3,967	3,967	1,765,172	0	60.00
65.00	06500	RESPIRATORY THERAPY	540	540	673,453	0	65.00
66.00	06600	PHYSICAL THERAPY	6,377	6,377	222	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	954	954	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	84	84	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	587	587	475,625	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,380	1,380	35,068	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
76.00	03020	ANCILLARY	0	0	0	0	76.00
76.01	03950	WOUND CARE	2,600	2,600	3,069	0	76.01
76.97	07697	CARDIAC REHABILITATION	1,510	1,510	125,788	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,623	3,623	595,358	0	90.00
91.00	09100	EMERGENCY	14,652	14,652	3,439,429	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)	270,503	270,503	38,402,674	-15,085,291	85,003,784
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,093	1,093	69,143	0	162,102
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	4,470,107
194.00	07950	FOUNDATION	202	202	138,922	0	186,423
194.01	07951	MARKETING	390	390	69,638	0	441,330
194.02	07952	PROF OFFICE BUILDINGS	0	0	0	0	79,486
194.03	07953	OP PHARMACY	234	234	171,365	0	372,254
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per wkst. B, Part I)	6,354,071	6,123,261	5,224,437		15,085,291
203.00		Unit cost multiplier (wkst. B, Part I)	23.324368	22.477116	0.134471		0.166292
204.00		Cost to be allocated (per wkst. B, Part II)			4,809		398,149
205.00		Unit cost multiplier (wkst. B, Part II)			0.000124		0.004389

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140304

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

Worksheet B-1

Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (TOTAL HOURS)	NURSING ADMINISTRATION (TOTAL HOURS)	
		7.00	9.00	10.00	11.00	13.00	
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	245,495					7.00
9.00	00900	1,662	243,833				9.00
10.00	01000	8,745	8,745	71,729			10.00
11.00	01100	3,261	3,261	0	843,842		11.00
13.00	01300	5,446	5,446	0	14,629	545,912	13.00
14.00	01400	5,773	5,773	0	19,185	0	14.00
15.00	01500	2,287	2,287	0	27,712	0	15.00
16.00	01600	3,401	3,401	0	14,797	0	16.00
17.00	01700	721	721	0	20,846	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	76,806	76,806	62,636	224,685	224,685	30.00
31.00	03100	11,823	11,823	9,093	47,264	47,264	31.00
43.00	04300	3,600	3,600	0	21,314	21,314	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	33,190	33,190	0	88,472	88,472	50.00
51.00	05100	3,556	3,556	0	10,595	10,595	51.00
52.00	05200	12,677	12,677	0	36,709	36,709	52.00
53.00	05300	623	623	0	2,109	2,109	53.00
54.00	05400	23,074	23,074	0	69,824	0	54.00
56.00	05600	7,304	7,304	0	3,821	0	56.00
57.00	05700	1,308	1,308	0	11,734	0	57.00
58.00	05800	920	920	0	5,041	0	58.00
59.00	05900	1,125	1,125	0	9,921	0	59.00
60.00	06000	3,967	3,967	0	54,909	0	60.00
65.00	06500	540	540	0	20,704	0	65.00
66.00	06600	6,377	6,377	0	7	0	66.00
67.00	06700	954	954	0	0	0	67.00
68.00	06800	84	84	0	0	0	68.00
69.00	06900	587	587	0	13,238	0	69.00
70.00	07000	1,380	1,380	0	1,154	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03950	2,600	2,600	0	59	0	76.01
76.97	07697	1,510	1,510	0	3,141	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	3,623	3,623	0	18,422	18,422	90.00
91.00	09100	14,652	14,652	0	96,342	96,342	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		243,576	241,914	71,729	836,634	545,912	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,093	1,093	0	1,824	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	202	202	0	3,712	0	194.00
194.01	07951	390	390	0	1,672	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	234	234	0	0	0	194.03
200.00							200.00
201.00							201.00
202.00		7,487,195	3,113,399	1,094,852	1,830,097	2,215,470	202.00
203.00		30.498360	12.768571	15.263729	2.168767	4.058291	203.00
204.00		859,438	93,466	437,197	168,381	280,967	204.00
205.00		3.500837	0.383320	6.095122	0.199541	0.514675	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140304

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

Worksheet B-1

Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
		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
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400	10,798,028				14.00
15.00	01500	22,638	3,590,275			15.00
16.00	01600	0	0	481,200,411		16.00
17.00	01700	0	1,272	0	22,259	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	484,335	44	28,564,734	17,153	30.00
31.00	03100	192,267	0	5,535,109	2,490	31.00
43.00	04300	53,792	0	2,706,968	2,458	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	1,102,233	17,042	48,332,844	0	50.00
51.00	05100	21,318	0	5,408,410	0	51.00
52.00	05200	99,954	0	5,028,584	158	52.00
53.00	05300	117,224	72,832	12,556,485	0	53.00
54.00	05400	44,410	502	46,282,989	0	54.00
56.00	05600	3,718	4,568	6,027,350	0	56.00
57.00	05700	74,881	0	49,304,447	0	57.00
58.00	05800	6,093	0	12,002,835	0	58.00
59.00	05900	56,656	9,258	5,340,350	0	59.00
60.00	06000	59,369	23	58,112,964	0	60.00
65.00	06500	94,814	0	8,541,577	0	65.00
66.00	06600	5,327	297	13,608,844	0	66.00
67.00	06700	0	0	969,870	0	67.00
68.00	06800	0	14,182	478,793	0	68.00
69.00	06900	3,263	0	13,178,116	0	69.00
70.00	07000	3,760	0	3,381,336	0	70.00
71.00	07100	2,443,297	1,167	13,689,969	0	71.00
72.00	07200	5,415,901	0	20,290,992	0	72.00
73.00	07300	0	3,460,615	43,011,863	0	73.00
74.00	07400	0	0	1,194,550	0	74.00
76.00	03020	0	0	0	0	76.00
76.01	03950	27,027	7,603	2,617,320	0	76.01
76.97	07697	1,113	0	637,402	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	44,133	102	6,002,294	0	90.00
91.00	09100	420,505	768	68,393,416	0	91.00
92.00	09200					92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00		10,798,028	3,590,275	481,200,411	22,259	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
194.03	07953	0	0	0	0	194.03
200.00						200.00
201.00						201.00
202.00		1,589,467	4,191,818	2,245,034	1,373,348	202.00
203.00		0.147200	1.167548	0.004665	61.698549	203.00
204.00		295,610	135,098	179,841	45,009	204.00
205.00		0.027376	0.037629	0.000374	2.022058	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140304

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

Worksheet C
Part I
Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		PPS	
				Total Costs	RCE Disallowance	Total Costs			
									1.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	21,528,644		21,528,644		0	21,528,644	30.00
31.00	03100	INTENSIVE CARE UNIT	4,935,495		4,935,495		0	4,935,495	31.00
43.00	04300	NURSERY	1,940,896		1,940,896		0	1,940,896	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	10,494,007		10,494,007		0	10,494,007	50.00
51.00	05100	RECOVERY ROOM	1,216,749		1,216,749		0	1,216,749	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,887,069		3,887,069		0	3,887,069	52.00
53.00	05300	ANESTHESIOLOGY	573,456		573,456		0	573,456	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,614,441		6,614,441		0	6,614,441	54.00
56.00	05600	RADIOISOTOPE	1,058,578		1,058,578		0	1,058,578	56.00
57.00	05700	CT SCAN	1,420,312		1,420,312		0	1,420,312	57.00
58.00	05800	MRI	610,544		610,544		0	610,544	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,106,035		1,106,035		0	1,106,035	59.00
60.00	06000	LABORATORY	5,577,101		5,577,101		0	5,577,101	60.00
65.00	06500	RESPIRATORY THERAPY	1,334,062	0	1,334,062		0	1,334,062	65.00
66.00	06600	PHYSICAL THERAPY	5,125,569	0	5,125,569		0	5,125,569	66.00
67.00	06700	OCCUPATIONAL THERAPY	327,224	0	327,224		0	327,224	67.00
68.00	06800	SPEECH PATHOLOGY	69,851	0	69,851		0	69,851	68.00
69.00	06900	ELECTROCARDIOLOGY	862,798		862,798		0	862,798	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	589,937		589,937		0	589,937	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,042,054		3,042,054		0	3,042,054	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,207,841		7,207,841		0	7,207,841	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,496,326		8,496,326		0	8,496,326	73.00
74.00	07400	RENAL DIALYSIS	393,708		393,708		0	393,708	74.00
76.00	03020	ANCILLARY	0		0		0	0	76.00
76.01	03950	WOUND CARE	1,074,349		1,074,349		0	1,074,349	76.01
76.97	07697	CARDIAC REHABILITATION	327,908		327,908		0	327,908	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	1,436,977		1,436,977		0	1,436,977	90.00
91.00	09100	EMERGENCY	7,788,671		7,788,671		0	7,788,671	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,713,962		3,713,962		0	3,713,962	92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	102,754,564	0	102,754,564		0	102,754,564	200.00
201.00		Less Observation Beds	3,713,962		3,713,962		0	3,713,962	201.00
202.00		Total (see instructions)	99,040,602	0	99,040,602		0	99,040,602	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140304

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

Worksheet C
Part I
Date/Time Prepared:
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		Title XVIII			Hospital	PPS
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
		Inpatient	Outpatient	Total (col. 6 + col. 7)		
		6.00	7.00	8.00		
	9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,832,324		20,832,324	30.00
31.00	03100	INTENSIVE CARE UNIT	5,535,109		5,535,109	31.00
43.00	04300	NURSERY	2,706,968		2,706,968	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,024,983	37,307,861	48,332,844	0.217120 50.00
51.00	05100	RECOVERY ROOM	1,588,290	3,820,120	5,408,410	0.224974 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,277,841	750,743	5,028,584	0.772995 52.00
53.00	05300	ANESTHESIOLOGY	4,256,880	8,299,605	12,556,485	0.045670 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,014,624	38,268,365	46,282,989	0.142913 54.00
56.00	05600	RADIOISOTOPE	1,331,980	4,695,370	6,027,350	0.175629 56.00
57.00	05700	CT SCAN	12,404,668	36,899,779	49,304,447	0.028807 57.00
58.00	05800	MRI	2,559,710	9,443,125	12,002,835	0.050867 58.00
59.00	05900	CARDIAC CATHETERIZATION	4,037,850	1,302,500	5,340,350	0.207109 59.00
60.00	06000	LABORATORY	27,463,018	30,649,946	58,112,964	0.095970 60.00
65.00	06500	RESPIRATORY THERAPY	7,337,306	1,204,271	8,541,577	0.156185 65.00
66.00	06600	PHYSICAL THERAPY	1,392,046	12,216,798	13,608,844	0.376635 66.00
67.00	06700	OCCUPATIONAL THERAPY	659,694	310,176	969,870	0.337390 67.00
68.00	06800	SPEECH PATHOLOGY	358,237	120,556	478,793	0.145890 68.00
69.00	06900	ELECTROCARDIOLOGY	4,990,902	8,187,214	13,178,116	0.065472 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	218,580	3,162,756	3,381,336	0.174469 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,945,287	8,744,682	13,689,969	0.222210 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,692,531	13,598,461	20,290,992	0.355224 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,870,123	21,141,740	43,011,863	0.197534 73.00
74.00	07400	RENAL DIALYSIS	1,194,550	0	1,194,550	0.329587 74.00
76.00	03020	ANCILLARY	0	0	0	0.000000 76.00
76.01	03950	WOUND CARE	41,725	2,575,595	2,617,320	0.410477 76.01
76.97	07697	CARDIAC REHABILITATION	5,808	631,594	637,402	0.514445 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	57,070	5,945,224	6,002,294	0.239405 90.00
91.00	09100	EMERGENCY	13,442,778	54,950,638	68,393,416	0.113880 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,063,558	6,668,852	7,732,410	0.480311 92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	170,304,440	310,895,971	481,200,411	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	170,304,440	310,895,971	481,200,411	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140304

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

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Part I
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Title XVIII

Hospital

PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
43.00	04300 NURSERY		43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.217120	50.00
51.00	05100 RECOVERY ROOM	0.224974	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.772995	52.00
53.00	05300 ANESTHESIOLOGY	0.045670	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.142913	54.00
56.00	05600 RADIOISOTOPE	0.175629	56.00
57.00	05700 CT SCAN	0.028807	57.00
58.00	05800 MRI	0.050867	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.207109	59.00
60.00	06000 LABORATORY	0.095970	60.00
65.00	06500 RESPIRATORY THERAPY	0.156185	65.00
66.00	06600 PHYSICAL THERAPY	0.376635	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.337390	67.00
68.00	06800 SPEECH PATHOLOGY	0.145890	68.00
69.00	06900 ELECTROCARDIOLOGY	0.065472	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.174469	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.222210	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.355224	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.197534	73.00
74.00	07400 RENAL DIALYSIS	0.329587	74.00
76.00	03020 ANCILLARY	0.000000	76.00
76.01	03950 WOUND CARE	0.410477	76.01
76.97	07697 CARDIAC REHABILITATION	0.514445	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.239405	90.00
91.00	09100 EMERGENCY	0.113880	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.480311	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: 140304

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Cost
				Total Costs	RCE Disallowance	Total Costs		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,528,644		21,528,644	0	21,528,644	30.00
31.00	03100	INTENSIVE CARE UNIT	4,935,495		4,935,495	0	4,935,495	31.00
43.00	04300	NURSERY	1,940,896		1,940,896	0	1,940,896	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,494,007		10,494,007	0	10,494,007	50.00
51.00	05100	RECOVERY ROOM	1,216,749		1,216,749	0	1,216,749	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,887,069		3,887,069	0	3,887,069	52.00
53.00	05300	ANESTHESIOLOGY	573,456		573,456	0	573,456	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,614,441		6,614,441	0	6,614,441	54.00
56.00	05600	RADIOISOTOPE	1,058,578		1,058,578	0	1,058,578	56.00
57.00	05700	CT SCAN	1,420,312		1,420,312	0	1,420,312	57.00
58.00	05800	MRI	610,544		610,544	0	610,544	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,106,035		1,106,035	0	1,106,035	59.00
60.00	06000	LABORATORY	5,577,101		5,577,101	0	5,577,101	60.00
65.00	06500	RESPIRATORY THERAPY	1,334,062	0	1,334,062	0	1,334,062	65.00
66.00	06600	PHYSICAL THERAPY	5,125,569	0	5,125,569	0	5,125,569	66.00
67.00	06700	OCCUPATIONAL THERAPY	327,224	0	327,224	0	327,224	67.00
68.00	06800	SPEECH PATHOLOGY	69,851	0	69,851	0	69,851	68.00
69.00	06900	ELECTROCARDIOLOGY	862,798		862,798	0	862,798	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	589,937		589,937	0	589,937	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,042,054		3,042,054	0	3,042,054	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,207,841		7,207,841	0	7,207,841	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,496,326		8,496,326	0	8,496,326	73.00
74.00	07400	RENAL DIALYSIS	393,708		393,708	0	393,708	74.00
76.00	03020	ANCILLARY	0		0	0	0	76.00
76.01	03950	WOUND CARE	1,074,349		1,074,349	0	1,074,349	76.01
76.97	07697	CARDIAC REHABILITATION	327,908		327,908	0	327,908	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,436,977		1,436,977	0	1,436,977	90.00
91.00	09100	EMERGENCY	7,788,671		7,788,671	0	7,788,671	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,713,962		3,713,962	0	3,713,962	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	102,754,564	0	102,754,564	0	102,754,564	200.00
201.00		Less Observation Beds	3,713,962		3,713,962		3,713,962	201.00
202.00		Total (see instructions)	99,040,602	0	99,040,602	0	99,040,602	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140304

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

Worksheet C
Part I
Date/Time Prepared:
5/18/2016 8:49 am

		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	20,832,324		20,832,324	30.00
31.00	03100	INTENSIVE CARE UNIT	5,535,109		5,535,109	31.00
43.00	04300	NURSERY	2,706,968		2,706,968	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,024,983	37,307,861	48,332,844	0.217120 50.00
51.00	05100	RECOVERY ROOM	1,588,290	3,820,120	5,408,410	0.224974 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,277,841	750,743	5,028,584	0.772995 52.00
53.00	05300	ANESTHESIOLOGY	4,256,880	8,299,605	12,556,485	0.045670 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,014,624	38,268,365	46,282,989	0.142913 54.00
56.00	05600	RADIOISOTOPE	1,331,980	4,695,370	6,027,350	0.175629 56.00
57.00	05700	CT SCAN	12,404,668	36,899,779	49,304,447	0.028807 57.00
58.00	05800	MRI	2,559,710	9,443,125	12,002,835	0.050867 58.00
59.00	05900	CARDIAC CATHETERIZATION	4,037,850	1,302,500	5,340,350	0.207109 59.00
60.00	06000	LABORATORY	27,463,018	30,649,946	58,112,964	0.095970 60.00
65.00	06500	RESPIRATORY THERAPY	7,337,306	1,204,271	8,541,577	0.156185 65.00
66.00	06600	PHYSICAL THERAPY	1,392,046	12,216,798	13,608,844	0.376635 66.00
67.00	06700	OCCUPATIONAL THERAPY	659,694	310,176	969,870	0.337390 67.00
68.00	06800	SPEECH PATHOLOGY	358,237	120,556	478,793	0.145890 68.00
69.00	06900	ELECTROCARDIOLOGY	4,990,902	8,187,214	13,178,116	0.065472 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	218,580	3,162,756	3,381,336	0.174469 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,945,287	8,744,682	13,689,969	0.222210 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,692,531	13,598,461	20,290,992	0.355224 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,870,123	21,141,740	43,011,863	0.197534 73.00
74.00	07400	RENAL DIALYSIS	1,194,550	0	1,194,550	0.329587 74.00
76.00	03020	ANCILLARY	0	0	0	0.000000 76.00
76.01	03950	WOUND CARE	41,725	2,575,595	2,617,320	0.410477 76.01
76.97	07697	CARDIAC REHABILITATION	5,808	631,594	637,402	0.514445 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	57,070	5,945,224	6,002,294	0.239405 90.00
91.00	09100	EMERGENCY	13,442,778	54,950,638	68,393,416	0.113880 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,063,558	6,668,852	7,732,410	0.480311 92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	170,304,440	310,895,971	481,200,411	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	170,304,440	310,895,971	481,200,411	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140304

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

Worksheet C
Part I
Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
76.00	03020	ANCILLARY	0.000000		76.00
76.01	03950	WOUND CARE	0.000000		76.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140304

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

Worksheet D
Part I
Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,472,801	0	4,472,801	20,729	215.78	30.00
31.00	INTENSIVE CARE UNIT	703,469		703,469	2,490	282.52	31.00
43.00	NURSERY	207,214		207,214	2,458	84.30	43.00
200.00	Total (lines 30-199)	5,383,484		5,383,484	25,677		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,282	1,355,530				
31.00	INTENSIVE CARE UNIT	938	265,004				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	7,220	1,620,534				

APPORIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140304

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

Worksheet D
Part II
Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,792,039	48,332,844	0.037077	3,686,184	136,673	50.00
51.00	05100	RECOVERY ROOM	190,567	5,408,410	0.035235	446,389	15,729	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	672,720	5,028,584	0.133779	16,310	2,182	52.00
53.00	05300	ANESTHESIOLOGY	44,514	12,556,485	0.003545	1,102,464	3,908	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,198,957	46,282,989	0.025905	3,372,409	87,362	54.00
56.00	05600	RADIOISOTOPE	368,854	6,027,350	0.061197	653,373	39,984	56.00
57.00	05700	CT SCAN	92,009	49,304,447	0.001866	4,508,473	8,413	57.00
58.00	05800	MRI	53,294	12,002,835	0.004440	774,064	3,437	58.00
59.00	05900	CARDIAC CATHETERIZATION	65,567	5,340,350	0.012278	1,290,582	15,846	59.00
60.00	06000	LABORATORY	250,481	58,112,964	0.004310	10,898,440	46,972	60.00
65.00	06500	RESPIRATORY THERAPY	41,397	8,541,577	0.004847	3,444,650	16,696	65.00
66.00	06600	PHYSICAL THERAPY	340,100	13,608,844	0.024991	756,497	18,906	66.00
67.00	06700	OCCUPATIONAL THERAPY	48,822	969,870	0.050339	347,751	17,505	67.00
68.00	06800	SPEECH PATHOLOGY	5,064	478,793	0.010577	196,749	2,081	68.00
69.00	06900	ELECTROCARDIOLOGY	39,694	13,178,116	0.003012	2,310,624	6,960	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	72,092	3,381,336	0.021321	82,542	1,760	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	81,901	13,689,969	0.005983	1,610,141	9,633	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	179,624	20,290,992	0.008852	2,479,474	21,948	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	162,317	43,011,863	0.003774	8,273,809	31,225	73.00
74.00	07400	RENAL DIALYSIS	1,908	1,194,550	0.001597	731,809	1,169	74.00
76.00	03020	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03950	WOUND CARE	134,725	2,617,320	0.051474	35,951	1,851	76.01
76.97	07697	CARDIAC REHABILITATION	76,887	637,402	0.120626	1,055	127	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	200,956	6,002,294	0.033480	10,036	336	90.00
91.00	09100	EMERGENCY	857,450	68,393,416	0.012537	5,033,173	63,101	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	771,613	7,732,410	0.099789	643,410	64,205	92.00
200.00		Total (lines 50-199)	7,743,552	452,126,010		52,706,359	618,009	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140304

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

Worksheet D
Part III
Date/Time Prepared:
5/18/2016 8:49 am

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	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	200.00
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	20,729	0.00	6,282	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,490	0.00	938	0	31.00
43.00	04300	NURSERY	2,458	0.00	0	0	43.00
200.00		Total (lines 30-199)	25,677		7,220	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140304

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

Worksheet D
Part IV
Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4) 5.00	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00				
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03020	ANCILLARY	0	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	0	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140304

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

Worksheet D
Part IV
Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		Title XVIII Hospital PPS					
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	48,332,844	0.000000	0.000000	3,686,184	50.00
51.00	05100 RECOVERY ROOM	0	5,408,410	0.000000	0.000000	446,389	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	5,028,584	0.000000	0.000000	16,310	52.00
53.00	05300 ANESTHESIOLOGY	0	12,556,485	0.000000	0.000000	1,102,464	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	46,282,989	0.000000	0.000000	3,372,409	54.00
56.00	05600 RADIOISOTOPE	0	6,027,350	0.000000	0.000000	653,373	56.00
57.00	05700 CT SCAN	0	49,304,447	0.000000	0.000000	4,508,473	57.00
58.00	05800 MRI	0	12,002,835	0.000000	0.000000	774,064	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	5,340,350	0.000000	0.000000	1,290,582	59.00
60.00	06000 LABORATORY	0	58,112,964	0.000000	0.000000	10,898,440	60.00
65.00	06500 RESPIRATORY THERAPY	0	8,541,577	0.000000	0.000000	3,444,650	65.00
66.00	06600 PHYSICAL THERAPY	0	13,608,844	0.000000	0.000000	756,497	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	969,870	0.000000	0.000000	347,751	67.00
68.00	06800 SPEECH PATHOLOGY	0	478,793	0.000000	0.000000	196,749	68.00
69.00	06900 ELECTROCARDIOLOGY	0	13,178,116	0.000000	0.000000	2,310,624	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	3,381,336	0.000000	0.000000	82,542	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,689,969	0.000000	0.000000	1,610,141	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	20,290,992	0.000000	0.000000	2,479,474	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	43,011,863	0.000000	0.000000	8,273,809	73.00
74.00	07400 RENAL DIALYSIS	0	1,194,550	0.000000	0.000000	731,809	74.00
76.00	03020 ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03950 WOUND CARE	0	2,617,320	0.000000	0.000000	35,951	76.01
76.97	07697 CARDIAC REHABILITATION	0	637,402	0.000000	0.000000	1,055	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	6,002,294	0.000000	0.000000	10,036	90.00
91.00	09100 EMERGENCY	0	68,393,416	0.000000	0.000000	5,033,173	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7,732,410	0.000000	0.000000	643,410	92.00
200.00	Total (lines 50-199)	0	452,126,010			52,706,359	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140304

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

Worksheet D
Part IV
Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		Title XVIII			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,122,158	0	50.00
51.00	05100	RECOVERY ROOM	0	393,572	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,195	0	52.00
53.00	05300	ANESTHESIOLOGY	0	961,640	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,053,809	0	54.00
56.00	05600	RADIOISOTOPE	0	1,328,802	0	56.00
57.00	05700	CT SCAN	0	5,821,981	0	57.00
58.00	05800	MRI	0	1,562,638	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	459,403	0	59.00
60.00	06000	LABORATORY	0	3,428,933	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	272,438	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
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	1,584,343	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	499,450	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,664,782	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,060,393	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,784,934	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03020	ANCILLARY	0	0	0	76.00
76.01	03950	WOUND CARE	0	1,066,679	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	212,511	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	540,764	0	90.00
91.00	09100	EMERGENCY	0	4,914,217	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,361,533	0	92.00
200.00		Total (lines 50-199)	0	46,096,175	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140304

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

Worksheet D
Part V
Date/Time Prepared:
5/18/2016 8:49 am

		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.)		
		2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.217120	7,122,158	0	0	1,546,363	50.00
51.00	05100 RECOVERY ROOM	0.224974	393,572	0	0	88,543	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.772995	1,195	0	0	924	52.00
53.00	05300 ANESTHESIOLOGY	0.045670	961,640	0	0	43,918	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.142913	5,053,809	0	0	722,255	54.00
56.00	05600 RADIOISOTOPE	0.175629	1,328,802	0	0	233,376	56.00
57.00	05700 CT SCAN	0.028807	5,821,981	0	0	167,714	57.00
58.00	05800 MRI	0.050867	1,562,638	0	0	79,487	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.207109	459,403	0	0	95,146	59.00
60.00	06000 LABORATORY	0.095970	3,428,933	0	0	329,075	60.00
65.00	06500 RESPIRATORY THERAPY	0.156185	272,438	0	0	42,551	65.00
66.00	06600 PHYSICAL THERAPY	0.376635	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.337390	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.145890	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.065472	1,584,343	0	0	103,730	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.174469	499,450	0	0	87,139	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.222210	1,664,782	0	0	369,931	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.355224	2,060,393	0	0	731,901	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.197534	5,784,934	0	84,893	1,142,721	73.00
74.00	07400 RENAL DIALYSIS	0.329587	0	0	0	0	74.00
76.00	03020 ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03950 WOUND CARE	0.410477	1,066,679	0	0	437,847	76.01
76.97	07697 CARDIAC REHABILITATION	0.514445	212,511	0	0	109,325	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.239405	540,764	0	0	129,462	90.00
91.00	09100 EMERGENCY	0.113880	4,914,217	0	0	559,631	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.480311	1,361,533	0	0	653,959	92.00
200.00	Subtotal (see instructions)		46,096,175	0	84,893	7,674,998	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		46,096,175	0	84,893	7,674,998	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140304

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

Worksheet D
Part V
Date/Time Prepared:
5/18/2016 8:49 am

		Title XVIII		Hospital	PPS
Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,769	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	ANCILLARY	0	0	76.00
76.01	03950	WOUND CARE	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	16,769	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	16,769	202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140304

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

Worksheet D-1

Date/Time Prepared:
5/18/2016 8:49 am

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)			20,729 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			20,729 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)			17,153 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)			6,282 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			21,528,644 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			21,528,644 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			21,528,644 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)			1,038.58 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			6,524,360 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)			6,524,360 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140304

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

Worksheet D-1

Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		Title XVIII			Hospital	PPS	
		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	4,935,495	2,490	1,982.13	938	1,859,238	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					8,191,574	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					16,575,172	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					1,620,534	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					618,009	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,238,543	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					14,336,629	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)					3,576	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,038.58	88.00
89.00	observation bed cost (line 87 x line 88) (see instructions)					3,713,962	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140304

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

worksheet D-1

Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description	Title XVIII			Hospital	PPS	
	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	4,472,801	21,528,644	0.207760	3,713,962	771,613	90.00
91.00 Nursing School cost	0	21,528,644	0.000000	3,713,962	0	91.00
92.00 Allied health cost	0	21,528,644	0.000000	3,713,962	0	92.00
93.00 All other Medical Education	0	21,528,644	0.000000	3,713,962	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140304

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

worksheet D-3

Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	PPS
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		6,769,746		30.00
31.00	03100 INTENSIVE CARE UNIT		2,142,310		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.217120	3,686,184	800,344	50.00
51.00	05100 RECOVERY ROOM	0.224974	446,389	100,426	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.772995	16,310	12,608	52.00
53.00	05300 ANESTHESIOLOGY	0.045670	1,102,464	50,350	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.142913	3,372,409	481,961	54.00
56.00	05600 RADIOISOTOPE	0.175629	653,373	114,751	56.00
57.00	05700 CT SCAN	0.028807	4,508,473	129,876	57.00
58.00	05800 MRI	0.050867	774,064	39,374	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.207109	1,290,582	267,291	59.00
60.00	06000 LABORATORY	0.095970	10,898,440	1,045,923	60.00
65.00	06500 RESPIRATORY THERAPY	0.156185	3,444,650	538,003	65.00
66.00	06600 PHYSICAL THERAPY	0.376635	756,497	284,923	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.337390	347,751	117,328	67.00
68.00	06800 SPEECH PATHOLOGY	0.145890	196,749	28,704	68.00
69.00	06900 ELECTROCARDIOLOGY	0.065472	2,310,624	151,281	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.174469	82,542	14,401	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.222210	1,610,141	357,789	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.355224	2,479,474	880,769	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.197534	8,273,809	1,634,359	73.00
74.00	07400 RENAL DIALYSIS	0.329587	731,809	241,195	74.00
76.00	03020 ANCILLARY	0.000000	0	0	76.00
76.01	03950 WOUND CARE	0.410477	35,951	14,757	76.01
76.97	07697 CARDIAC REHABILITATION	0.514445	1,055	543	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.239405	10,036	2,403	90.00
91.00	09100 EMERGENCY	0.113880	5,033,173	573,178	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.480311	643,410	309,037	92.00
200.00	Total (sum of lines 50-94 and 96-98)		52,706,359	8,191,574	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		52,706,359		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140304

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

Worksheet E
Part A
Date/Time Prepared:
5/18/2016 8:49 am

		Title XVIII	Hospital	PPS	
		0	1.00	2.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		10,019,273		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,666,173		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)		166,386		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)		130.12		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
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.38		30.00
31.00	Percentage of Medicaid patient days (see instructions)		27.04		31.00
32.00	Sum of lines 30 and 31		32.42		32.00
33.00	Allowable disproportionate share percentage (see instructions)		15.96		33.00
34.00	Disproportionate share adjustment (see instructions)		546,049		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140304

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

Worksheet E
Part A
Date/Time Prepared:
5/18/2016 8:49 am

		Title XVIII	Hospital	PPS	
			Prior to October 1	On/After October 1	
		0	1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)		0.000177308	0.000176435	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,355,985	1,130,266	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,014,202	284,110	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,298,312		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)			0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)			0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)			0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)			0	46.00
47.00	Subtotal (see instructions)		15,696,193		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)		15,696,193		49.00
50.00	Payment for inpatient program capital (from wkst. L, Pt. I and Pt. II, as applicable)		1,206,724		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)		16,902,917		59.00
60.00	Primary payer payments		15,253		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		16,887,664		61.00
62.00	Deductibles billed to program beneficiaries		1,391,816		62.00
63.00	Coinsurance billed to program beneficiaries		80,325		63.00
64.00	Allowable bad debts (see instructions)		381,435		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		247,933		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		301,887		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		15,663,456		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	RURAL DEMONSTRATION PROJECT			0	70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)		31,490		70.93
70.94	HRR adjustment amount (see instructions)		-71,629		70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140304

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

Worksheet E
Part A
Date/Time Prepared:
5/18/2016 8:49 am

		Title XVIII	Hospital		
			Prior to October 1	On/After October 1	PPS
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		15,623,317		71.00
71.01	Sequestration adjustment (see instructions)		312,466		71.01
72.00	Interim payments		15,380,079		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)		-69,228		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		395,239		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

		Title XVIII				Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)			
	0	1.00	2.00	3.00	4.00	5.00			
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,019,273	0	10,019,273	0	10,019,273	1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,666,173	0	0	3,666,173	3,666,173	1.02	
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03	
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04	
2.00	Outlier payments for discharges (see instructions)	2.00	166,386	0	133,231	33,155	166,386	2.00	
2.01	Outlier payments for discharges for Model 4 BPCI	2.01	0	0	0	0	0	2.01	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00	
Indirect Medical Education Adjustment									
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA									
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01	
Disproportionate Share Adjustment									
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1596	0.1596	0.1596	0.1596		10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	546,049	0	399,769	146,280	546,049	11.00	
11.01	Uncompensated care payments	36.00	1,298,312	0	1,014,202	284,110	1,298,312	11.01	
Additional payment for high percentage of ESRD beneficiary discharges									
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	15,696,193	0	11,566,475	4,129,718	15,696,193	13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,696,193	0	11,566,475	4,129,718	15,696,193	15.00	
16.00	Payment for inpatient program capital	50.00	1,206,724	0	879,932	326,792	1,206,724	16.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00	
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01	
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00	

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	12,446,407	4,456,510	16,902,917	19.00
		w/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,095,211	0	801,131	294,079	1,095,210	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	37,148	0	37,148	12,745	49,893	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0679	0.0679	0.0679	0.0679		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	74,365	0	54,397	19,968	74,365	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,206,724	0	879,932	326,792	1,206,724	26.00
		w/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to wkst. E, Pt. A.		Y					100.00

		Title XVIII			Hospital	PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,019,273	10,019,273		10,019,273	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,666,173		3,666,173	3,666,173	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	166,386	133,231	33,155	166,386	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1596	0.1596	0.1596		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	546,049	399,769	146,280	546,049	11.00
11.01	Uncompensated care payments	36.00	1,298,312	1,014,202	284,110	1,298,312	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	15,696,193	11,566,475	4,129,718	15,696,193	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,696,193	11,566,475	4,129,718	15,696,193	15.00
16.00	Payment for inpatient program capital	50.00	1,206,724	892,677	314,047	1,206,724	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			12,459,152	4,443,765	16,902,917	19.00

		Title XVIII			Hospital		PPS	
		Wkst. L, line	(Amt. from wkst. L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	1,095,211	801,132	294,079	1,095,211	20.00	
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01	
21.00	Capital DRG outlier payments	2.00	37,148	37,148	0	37,148	21.00	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0679	0.0679	0.0679		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	74,365	54,397	19,968	74,365	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	1,206,724	892,677	314,047	1,206,724	26.00	
		Wkst. E, Pt. A, line	(Amt. from wkst. E, Pt. A)					
		0	1.00	2.00	3.00	4.00		
27.00							27.00	
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00	
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00	
30.00	HVBP payment adjustment (see instructions)	70.93	31,490	33,122	-1,632	31,490	30.00	
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01	
31.00	HRR adjustment (see instructions)	70.94	-71,629	-51,098	-20,531	-71,629	31.00	
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01	
						(Amt. to wkst. E, Pt. A)		
		0	1.00	2.00	3.00	4.00		
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00	
100.00	Transfer HAC Reduction Program adjustment to wkst. E, Pt. A.		N				100.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140304	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/18/2016 8:49 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		16,769	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		7,674,998	2.00
3.00	PPS payments		8,278,393	3.00
4.00	Outlier payment (see instructions)		15,792	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)		16,769	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		84,893	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)		84,893	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)		84,893	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		68,124	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)		16,769	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)		8,294,185	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)		1,694,151	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)		6,616,803	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)		6,616,803	30.00
31.00	Primary payer payments		857	31.00
32.00	Subtotal (line 30 minus line 31)		6,615,946	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)		355,388	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		231,002	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		295,727	36.00
37.00	Subtotal (see instructions)		6,846,948	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		6,846,948	40.00
40.01	Sequestration adjustment (see instructions)		136,939	40.01
41.00	Interim payments		6,723,883	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-13,874	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: 140304

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

Worksheet E-1
Part I
Date/Time Prepared:
5/18/2016 8:49 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		15,291,463		6,675,661	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	11/12/2015	88,616	11/12/2015	48,222	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)		88,616		48,222	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)		15,380,079		6,723,883	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		69,228		13,874	6.02
7.00	Total Medicare program liability (see instructions)		15,310,851		6,710,009	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: 140304

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

Worksheet E-1
Part II
Date/Time Prepared:
5/18/2016 8:49 am

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			6,665 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			7,220 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			2,027 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			19,643 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			481,200,411 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			7,750,475 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			0 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			0 32.00

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

Provider CCN: 140304

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

Worksheet G

Date/Time Prepared: 5/18/2016 8:49 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-446,553	0	0	0	1.00
2.00	Temporary investments	9,089	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	30,424,553	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,588,758	0	0	0	6.00
7.00	Inventory	3,033,350	0	0	0	7.00
8.00	Prepaid expenses	883,622	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	26,315,303	0	0	0	11.00
FIXED ASSETS						
12.00	Land	5,440,226	0	0	0	12.00
13.00	Land improvements	84,552	0	0	0	13.00
14.00	Accumulated depreciation	-76,397	0	0	0	14.00
15.00	Buildings	110,291,477	0	0	0	15.00
16.00	Accumulated depreciation	-32,119,060	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	22,940,434	0	0	0	19.00
20.00	Accumulated depreciation	-12,819,720	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	38,548,156	0	0	0	23.00
24.00	Accumulated depreciation	-31,610,358	0	0	0	24.00
25.00	Minor equipment depreciable	529,296	0	0	0	25.00
26.00	Accumulated depreciation	-525,989	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	100,682,617	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,321,471	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	6,340,015	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,661,486	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	134,659,406	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	5,753,852	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,822,843	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,168,403	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	10,828,868	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	24,573,966	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	78,803,262	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	305,627	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	79,108,889	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	103,682,855	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	30,976,551	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)	30,976,551	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	134,659,406	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140304

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

Worksheet G-1

Date/Time Prepared:

5/18/2016 8:49 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		30,101,846			0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		3,999,701				2.00
3.00	Total (sum of line 1 and line 2)		34,101,547			0	3.00
4.00	DONOR RESTRICTED FUND BAL	209,223					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)		209,223			0	10.00
11.00	Subtotal (line 3 plus line 10)		34,310,770			0	11.00
12.00	GENERAL FUND BALANCE	3,333,384					12.00
13.00	ROUNDING	835					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)		3,334,219			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		30,976,551			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	DONOR RESTRICTED FUND BAL		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	GENERAL FUND BALANCE		0				12.00
13.00	ROUNDING		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: 140304

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/18/2016 8:49 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	22,442,694		22,442,694	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)	22,442,694		22,442,694	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,567,400		5,567,400	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,567,400		5,567,400	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	28,010,094		28,010,094	17.00
18.00	Ancillary services	126,757,490	258,499,001	385,256,491	18.00
19.00	Outpatient services	13,442,778	54,950,638	68,393,416	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	PHARMACY	0	344,001	344,001	27.00
27.01	PHYSICIAN REVENUE	0	1,042,756	1,042,756	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	168,210,362	314,836,396	483,046,758	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		118,730,910		29.00
30.00	BAD DEBT	7,759,405			30.00
31.00	ROUNDING	91			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)		7,759,496		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		126,490,406		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140304

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

worksheet G-3
Date/Time Prepared:
5/18/2016 8:49 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	483,046,758	1.00
2.00	Less contractual allowances and discounts on patients' accounts	355,532,275	2.00
3.00	Net patient revenues (line 1 minus line 2)	127,514,483	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	126,490,406	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,024,077	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	EHR REVENUE	2,975,624	24.00
25.00	Total other income (sum of lines 6-24)	2,975,624	25.00
26.00	Total (line 5 plus line 25)	3,999,701	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)	3,999,701	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140304	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/18/2016 8:49 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,095,211	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		37,148	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)		54.25	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)		5.38	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		27.04	8.00
9.00	Sum of lines 7 and 8		32.42	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.79	10.00
11.00	Disproportionate share adjustment (see instructions)		74,365	11.00
12.00	Total prospective capital payments (see instructions)		1,206,724	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