

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: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/24/2016 9:23 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/24/2016 Time: 9:23 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HOLY FAMILY MEDICAL CENTER (142011) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	508,917	55,093	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	508,917	55,093	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: 142011		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 5/20/2016 2:03 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 100 NORTH RIVER ROAD, SECOND FLOOR			PO Box:				1.00				
2.00	City: DES PLAINES			State: IL		Zip Code: 60016		County: COOK			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
								V	XVIII	XIX		
3.00	Hospital and Hospital-Based Component Identification:		HOLY FAMILY MEDICAL CENTER		142011	16974	2	03/01/2006	N	P	P	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.						N		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N		N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N		N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N		N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.								0		N	23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/20/2016 2:03 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
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	2.00	3.00
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				Y	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	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	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	97.00	
Rural Providers						
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical 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			109.00	
				1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N	110.00	
				1.00	2.00	
					3.00	
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00	
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	118.01	
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142011		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 5/20/2016 2:03 pm	
		1.00		2.00			
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		14H082		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: PRESENCE HEALTH	Contractor's Name: NGS		Contractor's Number: 00131			
142.00	Street: 200 S. WACKER DRIVE	PO Box:					
143.00	City: CHICAGO	State: IL		Zip Code: 60606			
		1.00		2.00			
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		2.00			
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	
		1.00		2.00		3.00	
		Title XIX		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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER	N		N		N	
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
		1.00		2.00			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00			
		Name		County		State	
		0		1.00		2.00	
		Zip Code		CBSA		FTE/Campus	
		3.00		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
		1.00		2.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	N		167.00			
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0			
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01			
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00			
		Beginning		Ending			
		1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/20/2016 2:03 pm	
				1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/20/2016 2:03 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/26/2016	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/20/2016 2:03 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICK		GILLI LAND	
42.00	Enter the employer/company name of the cost report preparer.	PRESENCE HEALTH			
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	8478133718		PATRICK.GILLI LAND@PRESENCEHEALTH.ORG	

		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)	04/26/2016	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REGIONAL DIRECTOR OF REIMBURSEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 142011

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

Worksheet S-3
Part I
Date/Time Prepared:
5/20/2016 2:03 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	120	43,800	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)		120	43,800	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		128	46,720	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)		128				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 142011

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

Worksheet S-3
Part I
Date/Time Prepared:
5/20/2016 2:03 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	16,530	951	32,020			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	16,530	951	32,020			7.00
8.00 INTENSIVE CARE UNIT	858	14	2,125			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)	17,388	965	34,145	0.45	565.64	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.45	565.64	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 142011

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

Worksheet S-3
Part I
Date/Time Prepared:
5/20/2016 2:03 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	539	29	1,488	1.00
2.00 HMO and other (see instructions)				0	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	539	29	1,488		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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 142011

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

Worksheet A
Date/Time Prepared:
5/20/2016 2:03 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT		3,886,107	3,886,107	-1,599,911	2,286,196	1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		0	0	3,652,242	3,652,242	2.00
3.00 00300 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	333,121	269,163	602,284	0	602,284	4.00
5.01 00540 NONPATIENT TELEPHONES	0	191,840	191,840	0	191,840	5.01
5.02 00550 DATA PROCESSING	0	0	0	0	0	5.02
5.03 00560 PURCHASING RECEIVING AND STORES	0	266	266	0	266	5.03
5.04 00570 ADMITTING	0	0	0	0	0	5.04
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE	140,997	112,256	253,253	-8,346	244,907	5.05
5.06 00590 ADMINISTRATIVE & GENERAL	5,225,145	16,041,593	21,266,738	-437,565	20,829,173	5.06
6.00 00600 MAINTENANCE & REPAIRS	436,620	364,702	801,322	-120	801,202	6.00
7.00 00700 OPERATION OF PLANT	411,977	2,794,121	3,206,098	-6,374	3,199,724	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	64,989	261,139	326,128	-108	326,020	8.00
9.00 00900 HOUSEKEEPING	890,651	647,658	1,538,309	-16,339	1,521,970	9.00
10.00 01000 DIETARY	656,865	1,376,453	2,033,318	-808,061	1,225,257	10.00
11.00 01100 CAFETERIA	0	0	0	811,331	811,331	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300 NURSING ADMINISTRATION	628,746	171,877	800,623	-1,357	799,266	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	69,238	365,932	435,170	-361,528	73,642	14.00
15.00 01500 PHARMACY	1,112,420	3,727,998	4,840,418	-3,470,014	1,370,404	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	356,442	197,573	554,015	-7,168	546,847	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	394,423	394,423	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	11,818,235	5,060,528	16,878,763	-2,356,654	14,522,109	30.00
31.00 03100 INTENSIVE CARE UNIT	1,612,887	527,718	2,140,605	-158,341	1,982,264	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,083,293	1,252,639	2,335,932	-767,555	1,568,377	50.00
53.00 05300 ANESTHESIOLOGY	0	300,919	300,919	-4,275	296,644	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	470,153	302,261	772,414	-120,986	651,428	54.00
56.00 05600 RADIOISOTOPE	36,278	27,092	63,370	-15,716	47,654	56.00
57.00 05700 CT SCAN	135,101	48,538	183,639	-19,918	163,721	57.00
57.01 03630 ULTRA SOUND	170,908	44,310	215,218	-3,078	212,140	57.01
58.00 05800 MRI	38,205	11,151	49,356	-3,040	46,316	58.00
60.00 06000 LABORATORY	0	2,283,800	2,283,800	27,394	2,311,194	60.00
65.00 06500 RESPIRATORY THERAPY	2,889,399	998,786	3,888,185	-250,482	3,637,703	65.00
66.00 06600 PHYSICAL THERAPY	2,325,690	657,121	2,982,811	-40,336	2,942,475	66.00
69.00 06900 ELECTROCARDIOLOGY	65,490	24,250	89,740	-7,038	82,702	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	217,709	77,984	295,693	-7,381	288,312	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,305,214	2,305,214	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	480,226	480,226	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	3,714,671	3,714,671	73.00
74.00 07400 RENAL DIALYSIS	569,744	255,017	824,761	-68,905	755,856	74.00
76.00 03950 SUBSTANCE ABUSE	94,453	31,118	125,571	796,190	921,761	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	776,718	1,007,702	1,784,420	-743,632	1,040,788	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	69,299	29,322	98,621	-10,707	87,914	90.00
90.02 09001 WOMENS DIAGNOSTIC CENTER	176,231	66,112	242,343	-8,129	234,214	90.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE		878,627	878,627	-878,627	0	113.00
118.00 118.00 SUBTOTALS (SUM OF LINES 1-117)	32,877,004	44,293,673	77,170,677	0	77,170,677	118.00
NONREIMBURSABLE COST CENTERS						
200.00 200.00 TOTAL (SUM OF LINES 118-199)	32,877,004	44,293,673	77,170,677	0	77,170,677	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 142011

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

Worksheet A
Date/Time Prepared:
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Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-150,221	2,135,975	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	96,937	3,749,179	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	465,520	1,067,804	4.00
5.01	00540	NONPATIENT TELEPHONES	0	191,840	5.01
5.02	00550	DATA PROCESSING	1,942,605	1,942,605	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	398,654	398,920	5.03
5.04	00570	ADMINITTING	0	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	807,998	1,052,905	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	-5,531,325	15,297,848	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	801,202	6.00
7.00	00700	OPERATION OF PLANT	0	3,199,724	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	326,020	8.00
9.00	00900	HOUSEKEEPING	0	1,521,970	9.00
10.00	01000	DIETARY	-15,926	1,209,331	10.00
11.00	01100	CAFETERIA	-333,193	478,138	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-4,200	795,066	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	92,727	166,369	14.00
15.00	01500	PHARMACY	-978	1,369,426	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,062	545,785	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	394,423	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-11,182	14,510,927	30.00
31.00	03100	INTENSIVE CARE UNIT	33,770	2,016,034	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,568,377	50.00
53.00	05300	ANESTHESIOLOGY	-293,736	2,908	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	651,428	54.00
56.00	05600	RADIOISOTOPE	0	47,654	56.00
57.00	05700	CT SCAN	0	163,721	57.00
57.01	03630	ULTRA SOUND	0	212,140	57.01
58.00	05800	MRI	0	46,316	58.00
60.00	06000	LABORATORY	-39,110	2,272,084	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,637,703	65.00
66.00	06600	PHYSICAL THERAPY	-610	2,941,865	66.00
69.00	06900	ELECTROCARDIOLOGY	0	82,702	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	288,312	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,305,214	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	480,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,714,671	73.00
74.00	07400	RENAL DIALYSIS	0	755,856	74.00
76.00	03950	SUBSTANCE ABUSE	0	921,761	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	1,040,788	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	87,914	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	-880	233,334	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,544,212	74,626,465	118.00
NONREIMBURSABLE COST CENTERS					
200.00		TOTAL (SUM OF LINES 118-199)	-2,544,212	74,626,465	200.00

RECLASSIFICATIONS

Provider CCN: 142011

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

Worksheet A-6
Date/Time Prepared:
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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RECLASS MOV EQUIPMENT DEPR EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,478,538	1.00
	TOTALS		0	2,478,538	
B - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	878,627	1.00
	TOTALS		0	878,627	
C - RECLASS DIETARY COSTS					
1.00	CAFETERIA	11.00	259,464	551,867	1.00
	TOTALS		259,464	551,867	
D - RECLASS SUPPLY COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,305,214	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	480,226	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	294,124	3.00
4.00	LABORATORY	60.00	0	30,314	4.00
5.00	DIETARY	10.00	0	12,488	5.00
6.00	PHARMACY	15.00	0	49,900	6.00
7.00		0.00	0	0	7.00
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
	TOTALS		0	3,172,266	
E - RECLASS DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,714,671	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,348	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
	TOTALS		0	3,719,019	
F - RECLASS RESIDENCY COSTS					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	284,159	110,264	1.00
	TOTALS		284,159	110,264	
G - RECLASS RENTAL COSTS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,173,704	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00

Provider CCN: 142011

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

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
	TOTALS		0	1,173,704		
H - RECLASS SUBSTANCE ABUSE						
1.00	SUBSTANCE ABUSE	76.00	600,926	195,274		1.00
	TOTALS		600,926	195,274		
500.00	Grand Total: Increases		1,144,549	12,279,559		500.00

RECLASSIFICATIONS

Provider CCN: 142011

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

Worksheet A-6
Date/Time Prepared:
5/20/2016 2:03 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - RECLASS MOV EQUIPMENT DEPR EXPENSE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,478,538	9		1.00
	TOTALS		0	2,478,538			
B - RECLASS INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	878,627	11		1.00
	TOTALS		0	878,627			
C - RECLASS DIETARY COSTS							
1.00	DIETARY	10.00	259,464	551,867	0		1.00
	TOTALS		259,464	551,867			
D - RECLASS SUPPLY COSTS							
1.00		0.00	0	0	0		1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	2,931	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.06	0	15,146	0		3.00
4.00	MAINTENANCE & REPAIRS	6.00	0	5	0		4.00
5.00	HOUSEKEEPING	9.00	0	16,129	0		5.00
6.00		0.00	0	0	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	640	0		7.00
9.00	ADULTS & PEDIATRICS	30.00	0	1,400,076	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	143,470	0		10.00
11.00	OPERATING ROOM	50.00	0	732,752	0		11.00
12.00	ANESTHESIOLOGY	53.00	0	3,674	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	109,385	0		13.00
14.00	RADIOISOTOPE	56.00	0	12,479	0		14.00
15.00	CT SCAN	57.00	0	16,172	0		15.00
16.00	ULTRA SOUND	57.01	0	3,078	0		16.00
17.00	MRI	58.00	0	1,659	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	236,126	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	25,587	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	928	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	4,834	0		21.00
22.00	RENAL DIALYSIS	74.00	0	66,814	0		22.00
23.00	HYPERBARIC OXYGEN THERAPY	76.98	0	364,741	0		23.00
24.00	CLINIC	90.00	0	7,813	0		24.00
25.00	WOMENS DIAGNOSTIC CENTER	90.02	0	5,989	0		25.00
26.00	OPERATION OF PLANT	7.00	0	1,828	0		26.00
27.00	SUBSTANCE ABUSE	76.00	0	10	0		27.00
	TOTALS		0	3,172,266			
E - RECLASS DRUG COSTS							
1.00	DIETARY	10.00	0	493	0		1.00
2.00		0.00	0	0	0		2.00
3.00	PHARMACY	15.00	0	3,516,520	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	134,733	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	14,250	0		5.00
6.00	OPERATING ROOM	50.00	0	18,882	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	601	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,793	0		8.00
9.00	RADIOISOTOPE	56.00	0	391	0		9.00
10.00	CT SCAN	57.00	0	3,712	0		10.00
11.00	MRI	58.00	0	1,381	0		11.00
12.00	LABORATORY	60.00	0	216	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	8,490	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	437	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	54	0		15.00
16.00	RENAL DIALYSIS	74.00	0	2,070	0		16.00
17.00	HYPERBARIC OXYGEN THERAPY	76.98	0	9,729	0		17.00
18.00	CLINIC	90.00	0	261	0		18.00
19.00	WOMENS DIAGNOSTIC CENTER	90.02	0	6	0		19.00
	TOTALS		0	3,719,019			
F - RECLASS RESIDENCY COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.06	284,159	110,264	0		1.00
	TOTALS		284,159	110,264			
G - RECLASS RENTAL COSTS							
1.00		0.00	0	0	10		1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	5,415	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.06	0	27,996	0		3.00
4.00	MAINTENANCE & REPAIRS	6.00	0	115	0		4.00
5.00	OPERATION OF PLANT	7.00	0	4,546	0		5.00
6.00	LAUNDRY & LINEN SERVICE	8.00	0	108	0		6.00
7.00	HOUSEKEEPING	9.00	0	210	0		7.00
8.00	DIETARY	10.00	0	8,725	0		8.00
9.00	NURSING ADMINISTRATION	13.00	0	717	0		9.00
10.00	CENTRAL SERVICES & SUPPLY	14.00	0	660,000	0		10.00

RECLASSIFICATIONS

Provider CCN: 142011

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

Worksheet A-6

Date/Time Prepared:
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		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
11.00	PHARMACY	15.00	0	3,394	0			11.00
12.00	MEDICAL RECORDS & LIBRARY	16.00	0	7,168	0			12.00
13.00	ADULTS & PEDIATRICS	30.00	0	25,645	0			13.00
14.00	INTENSIVE CARE UNIT	31.00	0	621	0			14.00
15.00	OPERATING ROOM	50.00	0	15,921	0			15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,808	0			16.00
17.00	RADIOISOTOPE	56.00	0	2,846	0			17.00
18.00	CT SCAN	57.00	0	34	0			18.00
19.00	RESPIRATORY THERAPY	65.00	0	5,866	0			19.00
20.00	PHYSICAL THERAPY	66.00	0	14,312	0			20.00
21.00	ELECTROCARDIOLOGY	69.00	0	6,056	0			21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,547	0			22.00
23.00	RENAL DIALYSIS	74.00	0	21	0			23.00
24.00	HYPERBARIC OXYGEN THERAPY	76.98	0	369,162	0			24.00
25.00	CLINIC	90.00	0	2,633	0			25.00
26.00	WOMENS DIAGNOSTIC CENTER	90.02	0	2,134	0			26.00
27.00	LABORATORY	60.00	0	2,704	0			27.00
	TOTALS		0	1,173,704				
H - RECLASS SUBSTANCE ABUSE								
1.00	ADULTS & PEDIATRICS	30.00	600,926	195,274	0			1.00
	TOTALS		600,926	195,274				
500.00	Grand Total: Decreases		1,144,549	12,279,559				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142011

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

Worksheet A-7
Part I
Date/Time Prepared:
5/20/2016 2:03 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	342,000	0	0	0	1.00
2.00	Land Improvements	4,077,827	0	0	0	2.00
3.00	Buildings and Fixtures	85,557,685	1,301,431	0	1,301,431	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	2,119,028	0	0	0	5.00
6.00	Movable Equipment	35,971,471	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	128,068,011	1,301,431	0	1,301,431	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	128,068,011	1,301,431	0	1,301,431	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	342,000	0			1.00
2.00	Land Improvements	4,077,827	0			2.00
3.00	Buildings and Fixtures	86,859,116	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	2,119,028	0			5.00
6.00	Movable Equipment	30,764,136	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	124,162,107	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	124,162,107	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142011

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

Worksheet A-7
Part II
Date/Time Prepared:
5/20/2016 2:03 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	3,886,107	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)	3,886,107	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	3,886,107				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	3,886,107				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142011

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

Worksheet A-7
Part III
Date/Time Prepared:
5/20/2016 2:03 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	92,096,540	0	92,096,540	0.719122	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	35,971,471	0	35,971,471	0.280878	0	2.00
3.00	Total (sum of lines 1-2)	128,068,011	0	128,068,011	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	1,601,787	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,575,475	1,173,704	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,177,262	1,173,704	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	534,188	0	0	0	2,135,975	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,749,179	2.00
3.00	Total (sum of lines 1-2)	534,188	0	0	0	5,885,154	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 142011

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

Worksheet A-8

Date/Time Prepared:
5/20/2016 2:03 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			3.00	4.00			
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)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-762,742				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	-1,001,965				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-333,193	CAFETERIA		11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-1,062	MEDICAL RECORDS & LIBRARY		16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines	B	-15,926	DIETARY		10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			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	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 OFFSET SUBSTANCE ABUSE REVENUE	B	-640	ADULTS & PEDIATRICS		30.00	0	33.00
33.01 MISC ADMIN INCOME	B	-65,037	ADMINISTRATIVE & GENERAL		5.06	0	33.01

Provider CCN: 142011

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

Worksheet A-8

Date/Time Prepared:
 5/20/2016 2:03 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
33.02 OFFSET INCOME TAX	A	-627	ADMINISTRATIVE & GENERAL	5.06	9 33.02
34.00 OFFSET FINANCE INTEREST INCOME	B	-1,655	ADMINISTRATIVE & GENERAL	5.06	0 34.00
35.00 OFFSET LAB INCOME	B	1,643	LABORATORY	60.00	0 35.00
36.00 OFFSET PATIENT TRANSPORT INCOME	B	-11,007	ADMINISTRATIVE & GENERAL	5.06	0 36.00
37.00 OFFSET PT INCOME	B	-610	PHYSICAL THERAPY	66.00	0 37.00
38.00 OFFSET CHILDCARE INCOME	B	-431,885	ADMINISTRATIVE & GENERAL	5.06	0 38.00
39.00 CY PORTION OF 1995 LOSS	A	10,120	CAP REL COSTS-MVBLE EQUIP	2.00	9 39.00
39.01 CURRENT YEAR PORTION OF 1996 LO	A	4,680	CAP REL COSTS-MVBLE EQUIP	2.00	9 39.01
39.02 1977 & 1983 EXCESS INTEREST	A	43,296	CAP REL COSTS-MVBLE EQUIP	2.00	9 39.02
39.03 DEMOLITION ADD BACK	A	32,256	CAP REL COSTS-MVBLE EQUIP	2.00	9 39.03
39.04 OFFSET PHARMACY INCOME	B	-978	PHARMACY	15.00	0 39.04
39.05 MAMMOGRAPHY INCOME	B	-880	WOMENS DIAGNOSTIC CENTER	90.02	0 39.05
39.06 TIERRA SERVICES INVOICES	A	-8,000	ADMINISTRATIVE & GENERAL	5.06	0 39.06
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,544,212			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: 142011

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

Worksheet A-8-1

Date/Time Prepared:
5/20/2016 2:03 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE CAPITAL	194,218	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE CAPITAL	6,585	0
3.00	5.06	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	4,194,366	8,793,716
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	EH&W	465,520	0
3.02	5.02	DATA PROCESSING	DATA PROCESSING	1,942,605	0
3.03	5.03	PURCHASING RECEIVING AND STO	PURCHASING	398,654	0
3.04	5.05	CASHIERING/ACCOUNTS RECEIVAB	PATIENT ACCTS	807,998	0
3.05	31.00	INTENSIVE CARE UNIT	ELECTRONIC ICU	33,770	0
3.06	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY	92,727	0
3.07	60.00	LABORATORY	ALVERNO LAB	2,069,898	2,070,151
3.08	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE INTEREST	-344,439	0
4.00	0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,861,902	10,863,867

* 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	RESURRECTION HEALTH CARE	100.00	0.00	6.00
7.00	C	ALVERNO LAB	66.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 142011

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

Worksheet A-8-1

Date/Time Prepared:
5/20/2016 2:03 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	194,218	9		1.00
2.00	6,585	9		2.00
3.00	-4,599,350	0		3.00
3.01	465,520	0		3.01
3.02	1,942,605	0		3.02
3.03	398,654	0		3.03
3.04	807,998	0		3.04
3.05	33,770	0		3.05
3.06	92,727	0		3.06
3.07	-253	0		3.07
3.08	-344,439	11		3.08
4.00	0	0		4.00
5.00	-1,001,965			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			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 142011

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

Worksheet A-8-2

Date/Time Prepared:
5/20/2016 2:03 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	53.00	ANESTHESIOLOGY	293,736	293,736	0	0	0	1.00
2.00	60.00	LABORATORY	40,500	40,500	0	0	0	2.00
3.00	5.06	ADMINISTRATIVE & GENERAL	349,637	349,637	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	33,950	0	33,950	179,000	272	4.00
5.00	5.06	ADMINISTRATIVE & GENERAL	205,778	0	205,778	179,000	1,646	5.00
6.00	13.00	NURSING ADMINISTRATION	4,200	4,200	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			927,801	688,073	239,728		1,918	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	5.06	ADMINISTRATIVE & GENERAL	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	23,408	1,170	0	0	0	4.00
5.00	5.06	ADMINISTRATIVE & GENERAL	141,651	7,083	0	0	0	5.00
6.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			165,059	8,253	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	53.00	ANESTHESIOLOGY	0	0	0	293,736	1.00
2.00	60.00	LABORATORY	0	0	0	40,500	2.00
3.00	5.06	ADMINISTRATIVE & GENERAL	0	0	0	349,637	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	23,408	10,542	10,542	4.00
5.00	5.06	ADMINISTRATIVE & GENERAL	0	141,651	64,127	64,127	5.00
6.00	13.00	NURSING ADMINISTRATION	0	0	0	4,200	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	165,059	74,669	762,742	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142011

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

Worksheet B
Part I
Date/Time Prepared:
5/20/2016 2:03 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,135,975	2,135,975			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	3,749,179		3,749,179		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,067,804	2,605	4,573	1,074,982	4.00
5.01 00540	NONPATIENT TELEPHONES	191,840	17,007	29,852	0	5.01
5.02 00550	DATA PROCESSING	1,942,605	0	0	0	5.02
5.03 00560	PURCHASING RECEIVING AND STORES	398,920	46,034	80,801	0	5.03
5.04 00570	ADMINISTRATIVE	0	0	0	0	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	1,052,905	0	0	4,657	5.05
5.06 00590	ADMINISTRATIVE & GENERAL	15,297,848	538,895	945,896	163,211	5.06
6.00 00600	MAINTENANCE & REPAIRS	801,202	81,523	143,094	14,422	6.00
7.00 00700	OPERATION OF PLANT	3,199,724	310,180	544,446	13,608	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	326,020	36,209	63,557	2,147	8.00
9.00 00900	HOUSEKEEPING	1,521,970	25,622	44,974	29,420	9.00
10.00 01000	DIETARY	1,209,331	105,210	184,670	13,127	10.00
11.00 01100	CAFETERIA	478,138	0	0	8,571	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	795,066	0	0	20,769	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	166,369	51,000	89,518	2,287	14.00
15.00 01500	PHARMACY	1,369,426	42,046	73,802	36,745	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	545,785	27,292	47,904	11,774	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	394,423	0	0	9,386	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	14,510,927	244,477	429,119	370,524	30.00
31.00 03100	INTENSIVE CARE UNIT	2,016,034	28,041	49,218	53,277	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,568,377	204,395	358,765	35,783	50.00
53.00 05300	ANESTHESIOLOGY	2,908	806	1,415	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	651,428	54,505	95,670	15,530	54.00
56.00 05600	RADIOISOTOPE	47,654	9,464	16,612	1,198	56.00
57.00 05700	CT SCAN	163,721	3,728	6,544	4,463	57.00
57.01 03630	ULTRA SOUND	212,140	5,146	9,033	5,645	57.01
58.00 05800	MRI	46,316	0	0	1,262	58.00
60.00 06000	LABORATORY	2,272,084	46,977	82,456	0	60.00
65.00 06500	RESPIRATORY THERAPY	3,637,703	3,829	6,721	95,443	65.00
66.00 06600	PHYSICAL THERAPY	2,941,865	81,581	143,195	76,822	66.00
69.00 06900	ELECTROCARDIOLOGY	82,702	12,948	22,727	2,163	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	288,312	22,024	38,657	7,191	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,305,214	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	480,226	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	3,714,671	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	755,856	2,354	4,131	18,820	74.00
76.00 03950	SUBSTANCE ABUSE	921,761	64,552	113,306	22,970	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	1,040,788	21,729	38,139	25,657	76.98
76.99 07699	LI THOTRI PSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	87,914	25,284	44,380	2,289	90.00
90.02 09001	WOMENS DIAGNOSTIC CENTER	233,334	20,512	36,004	5,821	90.02
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)	74,626,465	2,135,975	3,749,179	1,074,982	238,699
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	74,626,465	2,135,975	3,749,179	1,074,982	238,699

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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	1,958,836					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	40,305	571,470				5.03
5.04	00570	ADMINITTING	0	0	0			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	177,343	1,113	0	1,248,137		5.05
5.06	00590	ADMINISTRATIVE & GENERAL	596,519	22,707	0	0	17,607,276	5.06
6.00	00600	MAINTENANCE & REPAIRS	24,183	12,434	0	0	1,080,104	6.00
7.00	00700	OPERATION OF PLANT	8,061	8,932	0	0	4,089,496	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,061	11,916	0	0	447,910	8.00
9.00	00900	HOUSEKEEPING	8,061	12,916	0	0	1,644,694	9.00
10.00	01000	DIETARY	8,061	73,372	0	0	1,595,286	10.00
11.00	01100	CAFETERIA	8,061	0	0	0	496,934	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	132	0	0	816,400	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,061	0	0	0	319,399	14.00
15.00	01500	PHARMACY	40,305	5,112	0	0	1,572,197	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	177,343	436	0	0	826,332	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	403,809	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	112,855	34,510	0	380,161	16,142,084	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,597	0	31,201	2,182,450	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	104,794	21,306	0	65,358	2,377,822	50.00
53.00	05300	ANESTHESIOLOGY	0	29	0	15,544	22,217	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	266,015	1,778	0	17,039	1,120,360	54.00
56.00	05600	RADIOISOTOPE	0	27	0	2,142	77,097	56.00
57.00	05700	CT SCAN	0	190	0	17,086	195,732	57.00
57.01	03630	ULTRA SOUND	0	142	0	10,625	242,731	57.01
58.00	05800	MRI	8,061	8	0	4,594	60,674	58.00
60.00	06000	LABORATORY	209,587	18,585	0	110,517	2,752,974	60.00
65.00	06500	RESPIRATORY THERAPY	40,305	2,033	0	176,787	3,968,015	65.00
66.00	06600	PHYSICAL THERAPY	80,611	733	0	44,349	3,373,917	66.00
69.00	06900	ELECTROCARDIOLOGY	0	34	0	7,492	128,066	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	24,183	525	0	8,576	392,065	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	278,271	0	69,428	2,652,913	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	57,082	0	7,105	544,413	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	229,563	3,944,234	73.00
74.00	07400	RENAL DIALYSIS	0	236	0	14,606	796,219	74.00
76.00	03950	SUBSTANCE ABUSE	0	1,353	0	16,061	1,140,003	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	1,081	0	13,451	1,141,278	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	260	0	2,079	162,206	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	8,061	620	0	4,373	309,158	90.02
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)	1,958,836	571,470	0	1,248,137	74,626,465	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,958,836	571,470	0	1,248,137	74,626,465	202.00

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL	17,607,276					5.06
6.00	00600	MAINTENANCE & REPAIRS	333,532	1,413,636				6.00
7.00	00700	OPERATION OF PLANT	1,262,820	302,422	5,654,738			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	138,313	35,304	179,652	801,179		8.00
9.00	00900	HOUSEKEEPING	507,875	24,981	127,124	2,849	2,307,523	9.00
10.00	01000	DIETARY	492,618	102,577	521,994	0	225,229	10.00
11.00	01100	CAFETERIA	153,451	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	252,101	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	98,629	49,724	253,034	0	109,178	14.00
15.00	01500	PHARMACY	485,488	40,994	208,612	0	90,011	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	255,168	26,609	135,409	0	58,426	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	124,695	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,984,589	238,360	1,212,964	572,359	523,367	30.00
31.00	03100	INTENSIVE CARE UNIT	673,932	27,339	139,122	51,559	60,028	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	734,262	199,281	1,014,101	88,675	437,561	50.00
53.00	05300	ANESTHESIOLOGY	6,861	786	3,999	0	1,726	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	345,963	53,141	270,424	9,433	116,682	54.00
56.00	05600	RADIOISOTOPE	23,807	9,228	46,957	0	20,261	56.00
57.00	05700	CT SCAN	60,441	3,635	18,497	6,059	7,981	57.00
57.01	03630	ULTRA SOUND	74,954	5,017	25,532	6,203	11,016	57.01
58.00	05800	MRI	18,736	0	0	0	0	58.00
60.00	06000	LABORATORY	850,107	45,801	233,073	0	100,566	60.00
65.00	06500	RESPIRATORY THERAPY	1,225,307	3,733	18,997	603	8,197	65.00
66.00	06600	PHYSICAL THERAPY	1,041,852	79,540	404,762	23,880	174,645	66.00
69.00	06900	ELECTROCARDIOLOGY	39,546	12,624	64,241	861	27,718	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	121,068	21,473	109,270	511	47,147	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	819,209	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	168,113	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,217,964	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	245,869	2,295	11,677	0	5,038	74.00
76.00	03950	SUBSTANCE ABUSE	352,028	62,937	320,274	16,743	138,191	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	352,422	21,185	107,806	18,682	46,516	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	50,089	24,651	125,446	411	54,127	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	95,467	19,999	101,771	2,351	43,912	90.02
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)	17,607,276	1,413,636	5,654,738	801,179	2,307,523	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	17,607,276	1,413,636	5,654,738	801,179	2,307,523	202.00

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMINITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,937,704					10.00
11.00	01100	CAFETERIA	0	650,385				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	10,542	0	1,079,043		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,113	0	0	834,077	14.00
15.00	01500	PHARMACY	0	20,644	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,323	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,843,340	339,614	0	801,115	0	30.00
31.00	03100	INTENSIVE CARE UNIT	94,364	34,432	0	120,141	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	25,623	0	68,090	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,259	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	599	0	0	0	56.00
57.00	05700	CT SCAN	0	2,127	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	3,955	0	0	0	57.01
58.00	05800	MRI	0	678	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	81,156	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	55,438	0	371	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,576	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,319	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	690,277	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	143,800	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	12,355	0	35,047	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	3,514	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	19,871	0	46,408	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,670	0	7,871	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	3,577	0	0	0	90.02
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)	2,937,704	650,385	0	1,079,043	834,077	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,937,704	650,385	0	1,079,043	834,077	202.00

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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		
				SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
				15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 00100						1.00
2.00 00200						2.00
4.00 00400						4.00
5.01 00540						5.01
5.02 00550						5.02
5.03 00560						5.03
5.04 00570						5.04
5.05 00580						5.05
5.06 00590						5.06
6.00 00600						6.00
7.00 00700						7.00
8.00 00800						8.00
9.00 00900						9.00
10.00 01000						10.00
11.00 01100						11.00
12.00 01200						12.00
13.00 01300						13.00
14.00 01400						14.00
15.00 01500	2,417,946					15.00
16.00 01600	0	1,314,267				16.00
17.00 01700	0	0	0			17.00
21.00 02100	0	0	0	528,504		21.00
22.00 02200	0	0	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	0	400,158	0	528,504	0	30.00
31.00 03100	0	32,860	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	0	68,832	0	0	0	50.00
53.00 05300	0	16,370	0	0	0	53.00
54.00 05400	0	17,944	0	0	0	54.00
56.00 05600	0	2,256	0	0	0	56.00
57.00 05700	0	17,994	0	0	0	57.00
57.01 03630	0	11,190	0	0	0	57.01
58.00 05800	0	4,838	0	0	0	58.00
60.00 06000	0	116,391	0	0	0	60.00
65.00 06500	0	186,184	0	0	0	65.00
66.00 06600	0	46,706	0	0	0	66.00
69.00 06900	0	7,890	0	0	0	69.00
70.00 07000	0	9,032	0	0	0	70.00
71.00 07100	0	73,118	0	0	0	71.00
72.00 07200	0	7,483	0	0	0	72.00
73.00 07300	2,417,946	241,764	0	0	0	73.00
74.00 07400	0	15,382	0	0	0	74.00
76.00 03950	0	16,915	0	0	0	76.00
76.97 07697	0	0	0	0	0	76.97
76.98 07698	0	14,166	0	0	0	76.98
76.99 07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	0	2,189	0	0	0	90.00
90.02 09001	0	4,605	0	0	0	90.02
92.00 09200						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300						113.00
118.00	2,417,946	1,314,267	0	528,504	0	118.00
NONREIMBURSABLE COST CENTERS						
200.00				0	0	200.00
201.00	0	0	0	0	0	201.00
202.00	2,417,946	1,314,267	0	528,504	0	202.00

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00540				5.01
5.02	00550				5.02
5.03	00560				5.03
5.04	00570				5.04
5.05	00580				5.05
5.06	00590				5.06
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
12.00	01200				12.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
21.00	02100				21.00
22.00	02200				22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	28,586,454	-528,504	28,057,950	30.00
31.00	03100	3,416,227	0	3,416,227	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	5,014,247	0	5,014,247	50.00
53.00	05300	51,959	0	51,959	53.00
54.00	05400	1,944,206	0	1,944,206	54.00
56.00	05600	180,205	0	180,205	56.00
57.00	05700	312,466	0	312,466	57.00
57.01	03630	380,598	0	380,598	57.01
58.00	05800	84,926	0	84,926	58.00
60.00	06000	4,098,912	0	4,098,912	60.00
65.00	06500	5,492,192	0	5,492,192	65.00
66.00	06600	5,201,111	0	5,201,111	66.00
69.00	06900	282,522	0	282,522	69.00
70.00	07000	706,885	0	706,885	70.00
71.00	07100	4,235,517	0	4,235,517	71.00
72.00	07200	863,809	0	863,809	72.00
73.00	07300	7,821,908	0	7,821,908	73.00
74.00	07400	1,123,882	0	1,123,882	74.00
76.00	03950	2,050,605	0	2,050,605	76.00
76.97	07697	0	0	0	76.97
76.98	07698	1,768,334	0	1,768,334	76.98
76.99	07699	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	428,660	0	428,660	90.00
90.02	09001	580,840	0	580,840	90.02
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		74,626,465	-528,504	74,097,961	118.00
NONREIMBURSABLE COST CENTERS					
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		74,626,465	-528,504	74,097,961	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 142011

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

Worksheet B
Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,605	4,573	7,178	7,178 4.00
5.01 00540	NONPATIENT TELEPHONES	0	17,007	29,852	46,859	0 5.01
5.02 00550	DATA PROCESSING	0	0	0	0	0 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	0	46,034	80,801	126,835	0 5.03
5.04 00570	ADMITTING	0	0	0	0	0 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	31 5.05
5.06 00590	ADMINISTRATIVE & GENERAL	0	538,895	945,896	1,484,791	1,092 5.06
6.00 00600	MAINTENANCE & REPAIRS	0	81,523	143,094	224,617	96 6.00
7.00 00700	OPERATION OF PLANT	0	310,180	544,446	854,626	91 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	36,209	63,557	99,766	14 8.00
9.00 00900	HOUSEKEEPING	0	25,622	44,974	70,596	197 9.00
10.00 01000	DIETARY	0	105,210	184,670	289,880	88 10.00
11.00 01100	CAFETERIA	0	0	0	0	57 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	139 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	51,000	89,518	140,518	15 14.00
15.00 01500	PHARMACY	0	42,046	73,802	115,848	246 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	27,292	47,904	75,196	79 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	63 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	244,477	429,119	673,596	2,466 30.00
31.00 03100	INTENSIVE CARE UNIT	0	28,041	49,218	77,259	356 31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	204,395	358,765	563,160	239 50.00
53.00 05300	ANESTHESIOLOGY	0	806	1,415	2,221	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	54,505	95,670	150,175	104 54.00
56.00 05600	RADIOISOTOPE	0	9,464	16,612	26,076	8 56.00
57.00 05700	CT SCAN	0	3,728	6,544	10,272	30 57.00
57.01 03630	ULTRA SOUND	0	5,146	9,033	14,179	38 57.01
58.00 05800	MRI	0	0	0	0	8 58.00
60.00 06000	LABORATORY	0	46,977	82,456	129,433	0 60.00
65.00 06500	RESPIRATORY THERAPY	0	3,829	6,721	10,550	639 65.00
66.00 06600	PHYSICAL THERAPY	0	81,581	143,195	224,776	514 66.00
69.00 06900	ELECTROCARDIOLOGY	0	12,948	22,727	35,675	14 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	22,024	38,657	60,681	48 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	2,354	4,131	6,485	126 74.00
76.00 03950	SUBSTANCE ABUSE	0	64,552	113,306	177,858	154 76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	21,729	38,139	59,868	172 76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	25,284	44,380	69,664	15 90.00
90.02 09001	WOMENS DIAGNOSTIC CENTER	0	20,512	36,004	56,516	39 90.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,135,975	3,749,179	5,885,154	7,178 118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	2,135,975	3,749,179	5,885,154	7,178 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 142011

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

Worksheet B
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Cost Center Description		NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINING	CASHIERING/ACCOUNTS RECEIVABLE	
		5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540	46,859					5.01
5.02	00550		3,186				5.02
5.03	00560	1,062	66	127,963			5.03
5.04	00570	0	0	0	0		5.04
5.05	00580	2,379	288	249	0	2,947	5.05
5.06	00590	8,284	971	5,084	0	0	5.06
6.00	00600	637	39	2,784	0	0	6.00
7.00	00700	892	13	2,000	0	0	7.00
8.00	00800	0	13	2,668	0	0	8.00
9.00	00900	340	13	2,892	0	0	9.00
10.00	01000	297	13	16,429	0	0	10.00
11.00	01100	425	13	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	85	0	30	0	0	13.00
14.00	01400	425	13	0	0	0	14.00
15.00	01500	935	66	1,145	0	0	15.00
16.00	01600	3,101	288	98	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	11,683	184	7,727	0	859	30.00
31.00	03100	212	0	805	0	75	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,739	170	4,771	0	157	50.00
53.00	05300	297	0	6	0	37	53.00
54.00	05400	3,611	433	398	0	41	54.00
56.00	05600	0	0	6	0	5	56.00
57.00	05700	0	0	43	0	41	57.00
57.01	03630	0	0	32	0	26	57.01
58.00	05800	85	13	2	0	11	58.00
60.00	06000	2,507	341	4,161	0	266	60.00
65.00	06500	1,020	66	455	0	425	65.00
66.00	06600	935	131	164	0	107	66.00
69.00	06900	0	0	8	0	18	69.00
70.00	07000	510	39	118	0	21	70.00
71.00	07100	0	0	62,311	0	167	71.00
72.00	07200	0	0	12,782	0	17	72.00
73.00	07300	0	0	0	0	552	73.00
74.00	07400	42	0	53	0	35	74.00
76.00	03950	0	0	303	0	39	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	85	0	242	0	32	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	58	0	5	90.00
90.02	09001	85	13	139	0	11	90.02
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		46,859	3,186	127,963	0	2,947	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		46,859	3,186	127,963	0	2,947	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/20/2016 2:03 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.06	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00540	NONPATIENT TELEPHONES					5.01	
5.02	00550	DATA PROCESSING					5.02	
5.03	00560	PURCHASING RECEIVING AND STORES					5.03	
5.04	00570	ADMITTING					5.04	
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05	
5.06	00590	ADMINISTRATIVE & GENERAL	1,500,222				5.06	
6.00	00600	MAINTENANCE & REPAIRS	28,419	256,592			6.00	
7.00	00700	OPERATION OF PLANT	107,599	54,893	1,020,114		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	11,785	6,408	32,409	153,063	8.00	
9.00	00900	HOUSEKEEPING	43,274	4,534	22,933	544	145,323	9.00
10.00	01000	DIETARY	41,974	18,619	94,168	0	14,184	10.00
11.00	01100	CAFETERIA	13,075	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	21,480	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,404	9,025	45,647	0	6,876	14.00
15.00	01500	PHARMACY	41,366	7,441	37,634	0	5,669	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,742	4,830	24,428	0	3,680	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	10,625	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	424,703	43,265	218,819	109,348	32,961	30.00
31.00	03100	INTENSIVE CARE UNIT	57,422	4,962	25,098	9,850	3,780	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	62,563	36,172	182,944	16,941	27,557	50.00
53.00	05300	ANESTHESIOLOGY	585	143	721	0	109	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,478	9,646	48,785	1,802	7,348	54.00
56.00	05600	RADIOISOTOPE	2,028	1,675	8,471	0	1,276	56.00
57.00	05700	CT SCAN	5,150	660	3,337	1,158	503	57.00
57.01	03630	ULTRA SOUND	6,386	911	4,606	1,185	694	57.01
58.00	05800	MRI	1,596	0	0	0	0	58.00
60.00	06000	LABORATORY	72,433	8,313	42,046	0	6,333	60.00
65.00	06500	RESPIRATORY THERAPY	104,402	678	3,427	115	516	65.00
66.00	06600	PHYSICAL THERAPY	88,771	14,437	73,019	4,562	10,999	66.00
69.00	06900	ELECTROCARDIOLOGY	3,370	2,291	11,589	165	1,746	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,316	3,898	19,712	98	2,969	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	69,801	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,324	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	103,777	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	20,949	417	2,107	0	317	74.00
76.00	03950	SUBSTANCE ABUSE	29,995	11,424	57,777	3,199	8,703	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	30,028	3,845	19,448	3,569	2,929	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,268	4,475	22,630	78	3,409	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	8,134	3,630	18,359	449	2,765	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,500,222	256,592	1,020,114	153,063	145,323	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,500,222	256,592	1,020,114	153,063	145,323	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 142011		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 5/20/2016 2:03 pm	
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	475,652					10.00
11.00	01100	CAFETERIA	0	13,570				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	220	0	21,954		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	86	0	0	211,009	14.00
15.00	01500	PHARMACY	0	431	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	257	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	460,373	7,085	0	16,300	0	30.00
31.00	03100	INTENSIVE CARE UNIT	15,279	718	0	2,444	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	535	0	1,385	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	214	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	12	0	0	0	56.00
57.00	05700	CT SCAN	0	44	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	83	0	0	0	57.01
58.00	05800	MRI	0	14	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,693	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,157	0	8	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	33	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	132	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	174,630	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	36,379	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	258	0	713	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	73	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	415	0	944	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	35	0	160	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	75	0	0	0	90.02
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)	475,652	13,570	0	21,954	211,009	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	475,652	13,570	0	21,954	211,009	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 142011

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

Worksheet B
Part II
Date/Time Prepared:
5/20/2016 2:03 pm

Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS			
				SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
				15.00	16.00		17.00
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	
5.01 00540 NONPATIENT TELEPHONES						5.01	
5.02 00550 DATA PROCESSING						5.02	
5.03 00560 PURCHASING RECEIVING AND STORES						5.03	
5.04 00570 ADMITTING						5.04	
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.05	
5.06 00590 ADMINISTRATIVE & GENERAL						5.06	
6.00 00600 MAINTENANCE & REPAIRS						6.00	
7.00 00700 OPERATION OF PLANT						7.00	
8.00 00800 LAUNDRY & LINEN SERVICE						8.00	
9.00 00900 HOUSEKEEPING						9.00	
10.00 01000 DIETARY						10.00	
11.00 01100 CAFETERIA						11.00	
12.00 01200 MAINTENANCE OF PERSONNEL						12.00	
13.00 01300 NURSING ADMINISTRATION						13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00	
15.00 01500 PHARMACY	210,781					15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	133,699				16.00	
17.00 01700 SOCIAL SERVICE	0	0	0			17.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	10,688		21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		0	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	0	40,735	0			30.00	
31.00 03100 INTENSIVE CARE UNIT	0	3,342	0			31.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	7,000	0			50.00	
53.00 05300 ANESTHESIOLOGY	0	1,665	0			53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	1,825	0			54.00	
56.00 05600 RADIOISOTOPE	0	229	0			56.00	
57.00 05700 CT SCAN	0	1,830	0			57.00	
57.01 03630 ULTRA SOUND	0	1,138	0			57.01	
58.00 05800 MRI	0	492	0			58.00	
60.00 06000 LABORATORY	0	11,837	0			60.00	
65.00 06500 RESPIRATORY THERAPY	0	18,935	0			65.00	
66.00 06600 PHYSICAL THERAPY	0	4,750	0			66.00	
69.00 06900 ELECTROCARDIOLOGY	0	802	0			69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	919	0			70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,436	0			71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	761	0			72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	210,781	24,587	0			73.00	
74.00 07400 RENAL DIALYSIS	0	1,564	0			74.00	
76.00 03950 SUBSTANCE ABUSE	0	1,720	0			76.00	
76.97 07697 CARDIAC REHABILITATION	0	0	0			76.97	
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	1,441	0			76.98	
76.99 07699 LI THOTRI PSY	0	0	0			76.99	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	223	0			90.00	
90.02 09001 WOMENS DIAGNOSTIC CENTER	0	468	0			90.02	
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)					0	118.00
NONREIMBURSABLE COST CENTERS							
200.00	Cross Foot Adjustments					10,688	200.00
201.00	Negative Cost Centers					0	201.00
202.00	TOTAL (sum lines 118-201)					10,688	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 142011

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

Worksheet B
Part II
Date/Time Prepared:
5/20/2016 2:03 pm

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
5.01	00540				5.01
5.02	00550				5.02
5.03	00560				5.03
5.04	00570				5.04
5.05	00580				5.05
5.06	00590				5.06
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
12.00	01200				12.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
21.00	02100				21.00
22.00	02200				22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	2,050,104	0	2,050,104	30.00
31.00	03100	201,602	0	201,602	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	907,333	0	907,333	50.00
53.00	05300	5,784	0	5,784	53.00
54.00	05400	253,860	0	253,860	54.00
56.00	05600	39,786	0	39,786	56.00
57.00	05700	23,068	0	23,068	57.00
57.01	03630	29,278	0	29,278	57.01
58.00	05800	2,221	0	2,221	58.00
60.00	06000	277,670	0	277,670	60.00
65.00	06500	142,921	0	142,921	65.00
66.00	06600	424,330	0	424,330	66.00
69.00	06900	55,711	0	55,711	69.00
70.00	07000	99,461	0	99,461	70.00
71.00	07100	314,345	0	314,345	71.00
72.00	07200	64,263	0	64,263	72.00
73.00	07300	339,697	0	339,697	73.00
74.00	07400	33,066	0	33,066	74.00
76.00	03950	291,245	0	291,245	76.00
76.97	07697	0	0	0	76.97
76.98	07698	123,018	0	123,018	76.98
76.99	07699	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	105,020	0	105,020	90.00
90.02	09001	90,683	0	90,683	90.02
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		5,874,466	0	5,874,466	118.00
NONREIMBURSABLE COST CENTERS					
200.00		10,688	0	10,688	200.00
201.00		0	0	0	201.00
202.00		5,885,154	0	5,885,154	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142011

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF LINES)	DATA PROCESSING (NUMBER OF INSTRUMENT)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	296,776				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		296,776			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	362	362	32,543,883		4.00
5.01 00540	NONPATIENT TELEPHONES	2,363	2,363	0	1,103	5.01
5.02 00550	DATA PROCESSING	0	0	0	75	243 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	6,396	6,396	0	25	5 5.03
5.04 00570	ADMINISTRATIVE	0	0	0	0	0 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	140,997	56	22 5.05
5.06 00590	ADMINISTRATIVE & GENERAL	74,875	74,875	4,940,986	195	74 5.06
6.00 00600	MAINTENANCE & REPAIRS	11,327	11,327	436,620	15	3 6.00
7.00 00700	OPERATION OF PLANT	43,097	43,097	411,977	21	1 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	5,031	5,031	64,989	0	1 8.00
9.00 00900	HOUSEKEEPING	3,560	3,560	890,651	8	1 9.00
10.00 01000	DIETARY	14,618	14,618	397,401	7	1 10.00
11.00 01100	CAFETERIA	0	0	259,464	10	1 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	0	0	628,746	2	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	7,086	7,086	69,238	10	1 14.00
15.00 01500	PHARMACY	5,842	5,842	1,112,420	22	5 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,792	3,792	356,442	73	22 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	284,159	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	33,968	33,968	11,217,309	275	14 30.00
31.00 03100	INTENSIVE CARE UNIT	3,896	3,896	1,612,887	5	0 31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	28,399	28,399	1,083,293	88	13 50.00
53.00 05300	ANESTHESIOLOGY	112	112	0	7	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	7,573	7,573	470,153	85	33 54.00
56.00 05600	RADIOISOTOPE	1,315	1,315	36,278	0	0 56.00
57.00 05700	CT SCAN	518	518	135,101	0	0 57.00
57.01 03630	ULTRA SOUND	715	715	170,908	0	0 57.01
58.00 05800	MRI	0	0	38,205	2	1 58.00
60.00 06000	LABORATORY	6,527	6,527	0	59	26 60.00
65.00 06500	RESPIRATORY THERAPY	532	532	2,889,399	24	5 65.00
66.00 06600	PHYSICAL THERAPY	11,335	11,335	2,325,690	22	10 66.00
69.00 06900	ELECTROCARDIOLOGY	1,799	1,799	65,490	0	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	3,060	3,060	217,709	12	3 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	327	327	569,744	1	0 74.00
76.00 03950	SUBSTANCE ABUSE	8,969	8,969	695,379	0	0 76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	3,019	3,019	776,718	2	0 76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	3,513	3,513	69,299	0	0 90.00
90.02 09001	WOMENS DIAGNOSTIC CENTER	2,850	2,850	176,231	2	1 90.02
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)	296,776	296,776	32,543,883	1,103	243 118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	2,135,975	3,749,179	1,074,982	238,699	1,958,836 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7.197263	12.633026	0.033032	216.408885	8,061.053498 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			7,178	46,859	3,186 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000221	42.483228	13.111111 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142011

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			PURCHASING RECEIVING AND STORES (COST OF REQUISITIONS)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	4,807,740					5.03
5.04	00570	ADMITTING	0	0				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	9,360	0	333,336,678			5.05
5.06	00590	ADMINISTRATIVE & GENERAL	191,030	0	0	-17,607,276	57,019,189	5.06
6.00	00600	MAINTENANCE & REPAIRS	104,609	0	0	0	1,080,104	6.00
7.00	00700	OPERATION OF PLANT	75,140	0	0	0	4,089,496	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	100,247	0	0	0	447,910	8.00
9.00	00900	HOUSEKEEPING	108,664	0	0	0	1,644,694	9.00
10.00	01000	DIETARY	617,274	0	0	0	1,595,286	10.00
11.00	01100	CAFETERIA	0	0	0	0	496,934	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,112	0	0	0	816,400	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	319,399	14.00
15.00	01500	PHARMACY	43,009	0	0	0	1,572,197	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,665	0	0	0	826,332	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	403,809	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	290,329	0	101,505,441	0	16,142,084	30.00
31.00	03100	INTENSIVE CARE UNIT	30,259	0	8,333,685	0	2,182,450	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	179,248	0	17,456,697	0	2,377,822	50.00
53.00	05300	ANESTHESIOLOGY	243	0	4,151,703	0	22,217	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,957	0	4,550,965	0	1,120,360	54.00
56.00	05600	RADIOISOTOPE	230	0	572,107	0	77,097	56.00
57.00	05700	CT SCAN	1,600	0	4,563,624	0	195,732	57.00
57.01	03630	ULTRA SOUND	1,196	0	2,837,981	0	242,731	57.01
58.00	05800	MRI	64	0	1,226,908	0	60,674	58.00
60.00	06000	LABORATORY	156,351	0	29,518,418	0	2,752,974	60.00
65.00	06500	RESPIRATORY THERAPY	17,107	0	47,218,879	0	3,968,015	65.00
66.00	06600	PHYSICAL THERAPY	6,164	0	11,845,229	0	3,373,917	66.00
69.00	06900	ELECTROCARDIOLOGY	290	0	2,001,068	0	128,066	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,415	0	2,290,704	0	392,065	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,341,078	0	18,543,793	0	2,652,913	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	480,226	0	1,897,687	0	544,413	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	61,314,786	0	3,944,234	73.00
74.00	07400	RENAL DIALYSIS	1,984	0	3,901,134	0	796,219	74.00
76.00	03950	SUBSTANCE ABUSE	11,385	0	4,289,899	0	1,140,003	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	9,095	0	3,592,793	0	1,141,278	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,189	0	555,169	0	162,206	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	5,220	0	1,168,008	0	309,158	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,807,740	0	333,336,678	-17,607,276	57,019,189	118.00
NONREIMBURSABLE COST CENTERS								
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)	571,470	0	1,248,137		17,607,276	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.118865	0.000000	0.003744		0.308796	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	127,963	0	2,947		1,500,222	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.026616	0.000000	0.000009		0.026311	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142011

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
6.00	00600	201,453					6.00
7.00	00700	43,097	158,356				7.00
8.00	00800	5,031	5,031	478,031			8.00
9.00	00900	3,560	3,560	1,700	149,765		9.00
10.00	01000	14,618	14,618	0	14,618	99,248	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	7,086	7,086	0	7,086	0	14.00
15.00	01500	5,842	5,842	0	5,842	0	15.00
16.00	01600	3,792	3,792	0	3,792	0	16.00
17.00	01700	0	0	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	33,968	33,968	341,503	33,968	96,060	30.00
31.00	03100	3,896	3,896	30,763	3,896	3,188	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	28,399	28,399	52,909	28,399	0	50.00
53.00	05300	112	112	0	112	0	53.00
54.00	05400	7,573	7,573	5,628	7,573	0	54.00
56.00	05600	1,315	1,315	0	1,315	0	56.00
57.00	05700	518	518	3,615	518	0	57.00
57.01	03630	715	715	3,701	715	0	57.01
58.00	05800	0	0	0	0	0	58.00
60.00	06000	6,527	6,527	0	6,527	0	60.00
65.00	06500	532	532	360	532	0	65.00
66.00	06600	11,335	11,335	14,248	11,335	0	66.00
69.00	06900	1,799	1,799	514	1,799	0	69.00
70.00	07000	3,060	3,060	305	3,060	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	327	327	0	327	0	74.00
76.00	03950	8,969	8,969	9,990	8,969	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	3,019	3,019	11,147	3,019	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	3,513	3,513	245	3,513	0	90.00
90.02	09001	2,850	2,850	1,403	2,850	0	90.02
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		201,453	158,356	478,031	149,765	99,248	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00							201.00
202.00		1,413,636	5,654,738	801,179	2,307,523	2,937,704	202.00
203.00		7.017200	35.709023	1.675998	15.407625	29.599629	203.00
204.00		256,592	1,020,114	153,063	145,323	475,652	204.00
205.00		1.273707	6.441903	0.320195	0.970340	4.792560	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142011

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

Worksheet B-1

Date/Time Prepared:
5/20/2016 2:03 pm

Cost Center Description		CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	41,272					11.00
12.00	01200	0	0				12.00
13.00	01300	669	0	14,532			13.00
14.00	01400	261	0	0	2,785,440		14.00
15.00	01500	1,310	0	0	0	3,714,671	15.00
16.00	01600	782	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	21,551	0	10,789	0	0	30.00
31.00	03100	2,185	0	1,618	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,626	0	917	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	651	0	0	0	0	54.00
56.00	05600	38	0	0	0	0	56.00
57.00	05700	135	0	0	0	0	57.00
57.01	03630	251	0	0	0	0	57.01
58.00	05800	43	0	0	0	0	58.00
60.00	06000	0	0	0	0	0	60.00
65.00	06500	5,150	0	0	0	0	65.00
66.00	06600	3,518	0	5	0	0	66.00
69.00	06900	100	0	0	0	0	69.00
70.00	07000	401	0	0	0	0	70.00
71.00	07100	0	0	0	2,305,214	0	71.00
72.00	07200	0	0	0	480,226	0	72.00
73.00	07300	0	0	0	0	3,714,671	73.00
74.00	07400	784	0	472	0	0	74.00
76.00	03950	223	0	0	0	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	1,261	0	625	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	106	0	106	0	0	90.00
90.02	09001	227	0	0	0	0	90.02
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		41,272	0	14,532	2,785,440	3,714,671	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00							201.00
202.00		650,385	0	1,079,043	834,077	2,417,946	202.00
203.00		15.758505	0.000000	74.252890	0.299442	0.650918	203.00
204.00		13,570	0	21,954	211,009	210,781	204.00
205.00		0.328794	0.000000	1.510735	0.075754	0.056743	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142011

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

Worksheet B-1

Date/Time Prepared:
5/20/2016 2:03 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS			
			SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			16.00	17.00		
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
5.01 00540	NONPATIENT TELEPHONES					5.01
5.02 00550	DATA PROCESSING					5.02
5.03 00560	PURCHASING RECEIVING AND STORES					5.03
5.04 00570	ADMINISTRATIVE					5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 00590	ADMINISTRATIVE & GENERAL					5.06
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
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	333,336,678				16.00
17.00 01700	SOCIAL SERVICE	0	0			17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0		100		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	101,505,441	0	100	0	30.00
31.00 03100	INTENSIVE CARE UNIT	8,333,685	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	17,456,697	0	0	0	50.00
53.00 05300	ANESTHESIOLOGY	4,151,703	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,550,965	0	0	0	54.00
56.00 05600	RADIOISOTOPE	572,107	0	0	0	56.00
57.00 05700	CT SCAN	4,563,624	0	0	0	57.00
57.01 03630	ULTRA SOUND	2,837,981	0	0	0	57.01
58.00 05800	MRI	1,226,908	0	0	0	58.00
60.00 06000	LABORATORY	29,518,418	0	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	47,218,879	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	11,845,229	0	0	0	66.00
69.00 06900	ELECTROCARDIOLOGY	2,001,068	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	2,290,704	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,543,793	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,897,687	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	61,314,786	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	3,901,134	0	0	0	74.00
76.00 03950	SUBSTANCE ABUSE	4,289,899	0	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	3,592,793	0	0	0	76.98
76.99 07699	LI THOTRI PSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	555,169	0	0	0	90.00
90.02 09001	WOMENS DIAGNOSTIC CENTER	1,168,008	0	0	0	90.02
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)	333,336,678	0	100	0	118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,314,267	0	528,504	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.003943	0.000000	5,285.040000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	133,699	0	10,688	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000401	0.000000	106.880000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142011

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

Worksheet C
Part I
Date/Time Prepared:
5/20/2016 2:03 pm

		Title XVIII		Hospital		PPS
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	Total Costs
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	28,057,950		28,057,950	10,542	28,068,492
31.00	03100 INTENSIVE CARE UNIT	3,416,227		3,416,227	0	3,416,227
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5,014,247		5,014,247	0	5,014,247
53.00	05300 ANESTHESIOLOGY	51,959		51,959	0	51,959
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,944,206		1,944,206	0	1,944,206
56.00	05600 RADIOISOTOPE	180,205		180,205	0	180,205
57.00	05700 CT SCAN	312,466		312,466	0	312,466
57.01	03630 ULTRA SOUND	380,598		380,598	0	380,598
58.00	05800 MRI	84,926		84,926	0	84,926
60.00	06000 LABORATORY	4,098,912		4,098,912	0	4,098,912
65.00	06500 RESPIRATORY THERAPY	5,492,192	0	5,492,192	0	5,492,192
66.00	06600 PHYSICAL THERAPY	5,201,111	0	5,201,111	0	5,201,111
69.00	06900 ELECTROCARDIOLOGY	282,522		282,522	0	282,522
70.00	07000 ELECTROENCEPHALOGRAPHY	706,885		706,885	0	706,885
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4,235,517		4,235,517	0	4,235,517
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	863,809		863,809	0	863,809
73.00	07300 DRUGS CHARGED TO PATIENTS	7,821,908		7,821,908	0	7,821,908
74.00	07400 RENAL DIALYSIS	1,123,882		1,123,882	0	1,123,882
76.00	03950 SUBSTANCE ABUSE	2,050,605		2,050,605	0	2,050,605
76.97	07697 CARDIAC REHABILITATION	0		0	0	0
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,768,334		1,768,334	0	1,768,334
76.99	07699 LI THOTRI PSY	0		0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	428,660		428,660	0	428,660
90.02	09001 WOMENS DIAGNOSTIC CENTER	580,840		580,840	0	580,840
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	74,097,961	0	74,097,961	10,542	74,108,503
201.00	Less Observation Beds	0		0		0
202.00	Total (see instructions)	74,097,961	0	74,097,961	10,542	74,108,503

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142011

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

Worksheet C
Part I
Date/Time Prepared:
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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	Hospital		PPS			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	101,505,441		101,505,441			30.00
31.00	03100	INTENSIVE CARE UNIT	8,333,685		8,333,685			31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,310,823	16,145,874	17,456,697	0.287239	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	328,556	3,823,147	4,151,703	0.012515	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,323,786	1,227,179	4,550,965	0.427207	0.000000	54.00
56.00	05600	RADIOISOTOPE	118,346	453,761	572,107	0.314985	0.000000	56.00
57.00	05700	CT SCAN	3,186,183	1,377,441	4,563,624	0.068469	0.000000	57.00
57.01	03630	ULTRA SOUND	770,916	2,067,065	2,837,981	0.134109	0.000000	57.01
58.00	05800	MRI	2,628	1,224,280	1,226,908	0.069220	0.000000	58.00
60.00	06000	LABORATORY	23,529,961	5,988,457	29,518,418	0.138859	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	47,195,528	23,351	47,218,879	0.116313	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	9,265,451	2,579,778	11,845,229	0.439089	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,059,428	941,640	2,001,068	0.141186	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	120,344	2,170,360	2,290,704	0.308589	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,900,190	1,643,603	18,543,793	0.228406	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	273,426	1,624,261	1,897,687	0.455190	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,511,931	4,802,855	61,314,786	0.127570	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,901,134	0	3,901,134	0.288091	0.000000	74.00
76.00	03950	SUBSTANCE ABUSE	0	4,289,899	4,289,899	0.478008	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	122,186	3,470,607	3,592,793	0.492189	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	16,339	538,830	555,169	0.772125	0.000000	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	1,168,008	1,168,008	0.497291	0.000000	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	277,776,282	55,560,396	333,336,678			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	277,776,282	55,560,396	333,336,678			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/20/2016 2:03 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.287239		50.00
53.00	05300 ANESTHESIOLOGY	0.012515		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.427207		54.00
56.00	05600 RADIOISOTOPE	0.314985		56.00
57.00	05700 CT SCAN	0.068469		57.00
57.01	03630 ULTRA SOUND	0.134109		57.01
58.00	05800 MRI	0.069220		58.00
60.00	06000 LABORATORY	0.138859		60.00
65.00	06500 RESPIRATORY THERAPY	0.116313		65.00
66.00	06600 PHYSICAL THERAPY	0.439089		66.00
69.00	06900 ELECTROCARDIOLOGY	0.141186		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.308589		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.228406		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.455190		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.127570		73.00
74.00	07400 RENAL DIALYSIS	0.288091		74.00
76.00	03950 SUBSTANCE ABUSE	0.478008		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.492189		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.772125		90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.497291		90.02
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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142011

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

Worksheet C
Part I
Date/Time Prepared:
5/20/2016 2:03 pm

		Title XIX		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	28,057,950		28,057,950	10,542	28,068,492	30.00
31.00	03100 INTENSIVE CARE UNIT	3,416,227		3,416,227	0	3,416,227	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	5,014,247		5,014,247	0	5,014,247	50.00
53.00	05300 ANESTHESIOLOGY	51,959		51,959	0	51,959	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,944,206		1,944,206	0	1,944,206	54.00
56.00	05600 RADIOISOTOPE	180,205		180,205	0	180,205	56.00
57.00	05700 CT SCAN	312,466		312,466	0	312,466	57.00
57.01	03630 ULTRA SOUND	380,598		380,598	0	380,598	57.01
58.00	05800 MRI	84,926		84,926	0	84,926	58.00
60.00	06000 LABORATORY	4,098,912		4,098,912	0	4,098,912	60.00
65.00	06500 RESPIRATORY THERAPY	5,492,192	0	5,492,192	0	5,492,192	65.00
66.00	06600 PHYSICAL THERAPY	5,201,111	0	5,201,111	0	5,201,111	66.00
69.00	06900 ELECTROCARDIOLOGY	282,522		282,522	0	282,522	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	706,885		706,885	0	706,885	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4,235,517		4,235,517	0	4,235,517	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	863,809		863,809	0	863,809	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,821,908		7,821,908	0	7,821,908	73.00
74.00	07400 RENAL DIALYSIS	1,123,882		1,123,882	0	1,123,882	74.00
76.00	03950 SUBSTANCE ABUSE	2,050,605		2,050,605	0	2,050,605	76.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,768,334		1,768,334	0	1,768,334	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	428,660		428,660	0	428,660	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	580,840		580,840	0	580,840	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	74,097,961	0	74,097,961	10,542	74,108,503	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	74,097,961	0	74,097,961	10,542	74,108,503	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142011

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

Worksheet C
Part I
Date/Time Prepared:
5/20/2016 2:03 pm

		Title XIX			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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	101,505,441		101,505,441		30.00
31.00	03100	INTENSIVE CARE UNIT	8,333,685		8,333,685		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,310,823	16,145,874	17,456,697	0.287239	50.00
53.00	05300	ANESTHESIOLOGY	328,556	3,823,147	4,151,703	0.012515	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,323,786	1,227,179	4,550,965	0.427207	54.00
56.00	05600	RADIOISOTOPE	118,346	453,761	572,107	0.314985	56.00
57.00	05700	CT SCAN	3,186,183	1,377,441	4,563,624	0.068469	57.00
57.01	03630	ULTRA SOUND	770,916	2,067,065	2,837,981	0.134109	57.01
58.00	05800	MRI	2,628	1,224,280	1,226,908	0.069220	58.00
60.00	06000	LABORATORY	23,529,961	5,988,457	29,518,418	0.138859	60.00
65.00	06500	RESPIRATORY THERAPY	47,195,528	23,351	47,218,879	0.116313	65.00
66.00	06600	PHYSICAL THERAPY	9,265,451	2,579,778	11,845,229	0.439089	66.00
69.00	06900	ELECTROCARDIOLOGY	1,059,428	941,640	2,001,068	0.141186	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	120,344	2,170,360	2,290,704	0.308589	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,900,190	1,643,603	18,543,793	0.228406	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	273,426	1,624,261	1,897,687	0.455190	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,511,931	4,802,855	61,314,786	0.127570	73.00
74.00	07400	RENAL DIALYSIS	3,901,134	0	3,901,134	0.288091	74.00
76.00	03950	SUBSTANCE ABUSE	0	4,289,899	4,289,899	0.478008	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	122,186	3,470,607	3,592,793	0.492189	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	16,339	538,830	555,169	0.772125	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	1,168,008	1,168,008	0.497291	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	277,776,282	55,560,396	333,336,678		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	277,776,282	55,560,396	333,336,678		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/20/2016 2:03 pm
		Title XIX	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
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.287239		50.00
53.00	05300 ANESTHESIOLOGY	0.012515		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.427207		54.00
56.00	05600 RADIOISOTOPE	0.314985		56.00
57.00	05700 CT SCAN	0.068469		57.00
57.01	03630 ULTRA SOUND	0.134109		57.01
58.00	05800 MRI	0.069220		58.00
60.00	06000 LABORATORY	0.138859		60.00
65.00	06500 RESPIRATORY THERAPY	0.116313		65.00
66.00	06600 PHYSICAL THERAPY	0.439089		66.00
69.00	06900 ELECTROCARDIOLOGY	0.141186		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.308589		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.228406		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.455190		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.127570		73.00
74.00	07400 RENAL DIALYSIS	0.288091		74.00
76.00	03950 SUBSTANCE ABUSE	0.478008		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.492189		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.772125		90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.497291		90.02
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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 142011

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

Worksheet C Part II Date/Time Prepared: 5/20/2016 2:03 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,014,247	907,333	4,106,914	0	0	50.00
53.00	05300	ANESTHESIOLOGY	51,959	5,784	46,175	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,944,206	253,860	1,690,346	0	0	54.00
56.00	05600	RADIOISOTOPE	180,205	39,786	140,419	0	0	56.00
57.00	05700	CT SCAN	312,466	23,068	289,398	0	0	57.00
57.01	03630	ULTRA SOUND	380,598	29,278	351,320	0	0	57.01
58.00	05800	MRI	84,926	2,221	82,705	0	0	58.00
60.00	06000	LABORATORY	4,098,912	277,670	3,821,242	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,492,192	142,921	5,349,271	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,201,111	424,330	4,776,781	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	282,522	55,711	226,811	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	706,885	99,461	607,424	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,235,517	314,345	3,921,172	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	863,809	64,263	799,546	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,821,908	339,697	7,482,211	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,123,882	33,066	1,090,816	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	2,050,605	291,245	1,759,360	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,768,334	123,018	1,645,316	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	428,660	105,020	323,640	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	580,840	90,683	490,157	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	42,623,784	3,622,760	39,001,024	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	42,623,784	3,622,760	39,001,024	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 142011

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

Worksheet C Part II Date/Time Prepared: 5/20/2016 2:03 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	5,014,247	17,456,697	0.287239	50.00
53.00	05300 ANESTHESIOLOGY	51,959	4,151,703	0.012515	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,944,206	4,550,965	0.427207	54.00
56.00	05600 RADIOISOTOPE	180,205	572,107	0.314985	56.00
57.00	05700 CT SCAN	312,466	4,563,624	0.068469	57.00
57.01	03630 ULTRASOUND	380,598	2,837,981	0.134109	57.01
58.00	05800 MRI	84,926	1,226,908	0.069220	58.00
60.00	06000 LABORATORY	4,098,912	29,518,418	0.138859	60.00
65.00	06500 RESPIRATORY THERAPY	5,492,192	47,218,879	0.116313	65.00
66.00	06600 PHYSICAL THERAPY	5,201,111	11,845,229	0.439089	66.00
69.00	06900 ELECTROCARDIOLOGY	282,522	2,001,068	0.141186	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	706,885	2,290,704	0.308589	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4,235,517	18,543,793	0.228406	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	863,809	1,897,687	0.455190	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,821,908	61,314,786	0.127570	73.00
74.00	07400 RENAL DIALYSIS	1,123,882	3,901,134	0.288091	74.00
76.00	03950 SUBSTANCE ABUSE	2,050,605	4,289,899	0.478008	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,768,334	3,592,793	0.492189	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	428,660	555,169	0.772125	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	580,840	1,168,008	0.497291	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	42,623,784	223,497,552		200.00
201.00	Less Observation Beds	0	0		201.00
202.00	Total (line 200 minus line 201)	42,623,784	223,497,552		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 142011		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part I Date/Time Prepared: 5/20/2016 2:03 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,050,104	0	2,050,104	32,020	64.03	
31.00	INTENSIVE CARE UNIT	201,602		201,602	2,125	94.87	
200.00	Total (Lines 30-199)	2,251,706		2,251,706	34,145	200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	16,530	1,058,416	30.00			
31.00	INTENSIVE CARE UNIT	858	81,398	31.00			
200.00	Total (Lines 30-199)	17,388	1,139,814	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 5/20/2016 2:03 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	907,333	17,456,697	0.051976	719,855	37,415	50.00
53.00	05300 ANESTHESIOLOGY	5,784	4,151,703	0.001393	181,443	253	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	253,860	4,550,965	0.055782	1,850,396	103,219	54.00
56.00	05600 RADIOISOTOPE	39,786	572,107	0.069543	64,229	4,467	56.00
57.00	05700 CT SCAN	23,068	4,563,624	0.005055	1,542,252	7,796	57.00
57.01	03630 ULTRA SOUND	29,278	2,837,981	0.010316	407,499	4,204	57.01
58.00	05800 MRI	2,221	1,226,908	0.001810	1,250	2	58.00
60.00	06000 LABORATORY	277,670	29,518,418	0.009407	12,639,418	118,899	60.00
65.00	06500 RESPIRATORY THERAPY	142,921	47,218,879	0.003027	26,027,385	78,785	65.00
66.00	06600 PHYSICAL THERAPY	424,330	11,845,229	0.035823	5,150,215	184,496	66.00
69.00	06900 ELECTROCARDIOLOGY	55,711	2,001,068	0.027841	573,212	15,959	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	99,461	2,290,704	0.043419	64,470	2,799	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	314,345	18,543,793	0.016951	10,136,409	171,822	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	64,263	1,897,687	0.033864	139,747	4,732	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	339,697	61,314,786	0.005540	29,887,722	165,578	73.00
74.00	07400 RENAL DIALYSIS	33,066	3,901,134	0.008476	2,002,257	16,971	74.00
76.00	03950 SUBSTANCE ABUSE	291,245	4,289,899	0.067891	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	123,018	3,592,793	0.034240	50,352	1,724	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	105,020	555,169	0.189168	9,929	1,878	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	90,683	1,168,008	0.077639	0	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00	Total (lines 50-199)	3,622,760	223,497,552		91,448,040	920,999	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 142011		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part III Date/Time Prepared: 5/20/2016 2:03 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,020	0.00	16,530	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,125	0.00	858	0		31.00
200.00		Total (lines 30-199)	34,145		17,388	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142011

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

Worksheet D
Part IV
Date/Time Prepared:
5/20/2016 2:03 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	03950	SUBSTANCE ABUSE	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/20/2016 2:03 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	17,456,697	0.000000	0.000000	719,855	50.00
53.00	05300 ANESTHESIOLOGY	0	4,151,703	0.000000	0.000000	181,443	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	4,550,965	0.000000	0.000000	1,850,396	54.00
56.00	05600 RADIOISOTOPE	0	572,107	0.000000	0.000000	64,229	56.00
57.00	05700 CT SCAN	0	4,563,624	0.000000	0.000000	1,542,252	57.00
57.01	03630 ULTRA SOUND	0	2,837,981	0.000000	0.000000	407,499	57.01
58.00	05800 MRI	0	1,226,908	0.000000	0.000000	1,250	58.00
60.00	06000 LABORATORY	0	29,518,418	0.000000	0.000000	12,639,418	60.00
65.00	06500 RESPIRATORY THERAPY	0	47,218,879	0.000000	0.000000	26,027,385	65.00
66.00	06600 PHYSICAL THERAPY	0	11,845,229	0.000000	0.000000	5,150,215	66.00
69.00	06900 ELECTROCARDIOLOGY	0	2,001,068	0.000000	0.000000	573,212	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,290,704	0.000000	0.000000	64,470	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	18,543,793	0.000000	0.000000	10,136,409	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,897,687	0.000000	0.000000	139,747	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	61,314,786	0.000000	0.000000	29,887,722	73.00
74.00	07400 RENAL DIALYSIS	0	3,901,134	0.000000	0.000000	2,002,257	74.00
76.00	03950 SUBSTANCE ABUSE	0	4,289,899	0.000000	0.000000	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	3,592,793	0.000000	0.000000	50,352	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	555,169	0.000000	0.000000	9,929	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0	1,168,008	0.000000	0.000000	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	223,497,552			91,448,040	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/20/2016 2:03 pm
Title XVIII		Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	4,323,715	0	50.00
53.00	05300 ANESTHESIOLOGY	0	1,017,363	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	493,467	0	54.00
56.00	05600 RADIOISOTOPE	0	207,734	0	56.00
57.00	05700 CT SCAN	0	718,528	0	57.00
57.01	03630 ULTRA SOUND	0	512,479	0	57.01
58.00	05800 MRI	0	327,563	0	58.00
60.00	06000 LABORATORY	0	705,502	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	3,088	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	372,355	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	578,678	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	651,260	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	599,003	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,513,136	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03950 SUBSTANCE ABUSE	0	1,278	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	1,689,689	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	211,885	0	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0	108,565	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
200.00	Total (lines 50-199)	0	15,035,288	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/20/2016 2:03 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.287239	4,323,715	0	0	1,241,940	50.00
53.00	05300 ANESTHESIOLOGY	0.012515	1,017,363	0	0	12,732	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.427207	493,467	0	0	210,813	54.00
56.00	05600 RADIOISOTOPE	0.314985	207,734	0	0	65,433	56.00
57.00	05700 CT SCAN	0.068469	718,528	0	0	49,197	57.00
57.01	03630 ULTRASOUND	0.134109	512,479	0	0	68,728	57.01
58.00	05800 MRI	0.069220	327,563	0	0	22,674	58.00
60.00	06000 LABORATORY	0.138859	705,502	0	0	97,965	60.00
65.00	06500 RESPIRATORY THERAPY	0.116313	3,088	0	0	359	65.00
66.00	06600 PHYSICAL THERAPY	0.439089	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.141186	372,355	0	0	52,571	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.308589	578,678	0	0	178,574	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.228406	651,260	0	0	148,752	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.455190	599,003	0	0	272,660	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.127570	2,513,136	0	11,208	320,601	73.00
74.00	07400 RENAL DIALYSIS	0.288091	0	0	0	0	74.00
76.00	03950 SUBSTANCE ABUSE	0.478008	1,278	0	0	611	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.492189	1,689,689	0	0	831,646	76.98
76.99	07699 LI THOTRIPTY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.772125	211,885	0	0	163,602	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.497291	108,565	0	0	53,988	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Subtotal (see instructions)		15,035,288	0	11,208	3,792,846	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		15,035,288	0	11,208	3,792,846	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/20/2016 2:03 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
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
57.01 03630 ULTRASOUND	0	0		57.01
58.00 05800 MRI	0	0		58.00
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
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	1,430		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03950 SUBSTANCE ABUSE	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.02 09001 WOMENS DIAGNOSTIC CENTER	0	0		90.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	0	1,430		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	1,430		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 142011		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part I Date/Time Prepared: 5/20/2016 2:03 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,050,104	0	2,050,104	32,020	64.03	30.00
31.00	INTENSIVE CARE UNIT	201,602		201,602	2,125	94.87	31.00
200.00	Total (Lines 30-199)	2,251,706		2,251,706	34,145		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	951	60,893				
31.00	INTENSIVE CARE UNIT	14	1,328				
200.00	Total (Lines 30-199)	965	62,221				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 5/20/2016 2:03 pm
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Cost Center Description		Title XIX			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	907,333	17,456,697	0.051976	45,784	2,380	50.00
53.00	05300 ANESTHESIOLOGY	5,784	4,151,703	0.001393	11,183	16	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	253,860	4,550,965	0.055782	134,446	7,500	54.00
56.00	05600 RADIOISOTOPE	39,786	572,107	0.069543	5,446	379	56.00
57.00	05700 CT SCAN	23,068	4,563,624	0.005055	205,225	1,037	57.00
57.01	03630 ULTRA SOUND	29,278	2,837,981	0.010316	70,196	724	57.01
58.00	05800 MRI	2,221	1,226,908	0.001810	0	0	58.00
60.00	06000 LABORATORY	277,670	29,518,418	0.009407	1,233,992	11,608	60.00
65.00	06500 RESPIRATORY THERAPY	142,921	47,218,879	0.003027	1,977,157	5,985	65.00
66.00	06600 PHYSICAL THERAPY	424,330	11,845,229	0.035823	666,476	23,875	66.00
69.00	06900 ELECTROCARDIOLOGY	55,711	2,001,068	0.027841	87,107	2,425	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	99,461	2,290,704	0.043419	5,777	251	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	314,345	18,543,793	0.016951	1,052,041	17,833	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	64,263	1,897,687	0.033864	6,902	234	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	339,697	61,314,786	0.005540	4,311,442	23,885	73.00
74.00	07400 RENAL DIALYSIS	33,066	3,901,134	0.008476	70,782	600	74.00
76.00	03950 SUBSTANCE ABUSE	291,245	4,289,899	0.067891	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	123,018	3,592,793	0.034240	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	105,020	555,169	0.189168	0	0	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	90,683	1,168,008	0.077639	0	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00	Total (lines 50-199)	3,622,760	223,497,552		9,883,956	98,732	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 142011		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part III Date/Time Prepared: 5/20/2016 2:03 pm	
Cost Center Description			Title XIX		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,020	0.00	951	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,125	0.00	14	0		31.00
200.00		Total (lines 30-199)	34,145		965	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142011

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

Worksheet D
Part IV
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Cost Center Description		Title XIX			Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/20/2016 2:03 pm
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Cost Center Description		Title XIX			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	17,456,697	0.000000	0.000000	45,784	50.00
53.00	05300	ANESTHESIOLOGY	0	4,151,703	0.000000	0.000000	11,183	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,550,965	0.000000	0.000000	134,446	54.00
56.00	05600	RADIOISOTOPE	0	572,107	0.000000	0.000000	5,446	56.00
57.00	05700	CT SCAN	0	4,563,624	0.000000	0.000000	205,225	57.00
57.01	03630	ULTRA SOUND	0	2,837,981	0.000000	0.000000	70,196	57.01
58.00	05800	MRI	0	1,226,908	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	29,518,418	0.000000	0.000000	1,233,992	60.00
65.00	06500	RESPIRATORY THERAPY	0	47,218,879	0.000000	0.000000	1,977,157	65.00
66.00	06600	PHYSICAL THERAPY	0	11,845,229	0.000000	0.000000	666,476	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,001,068	0.000000	0.000000	87,107	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,290,704	0.000000	0.000000	5,777	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	18,543,793	0.000000	0.000000	1,052,041	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,897,687	0.000000	0.000000	6,902	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	61,314,786	0.000000	0.000000	4,311,442	73.00
74.00	07400	RENAL DIALYSIS	0	3,901,134	0.000000	0.000000	70,782	74.00
76.00	03950	SUBSTANCE ABUSE	0	4,289,899	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	3,592,793	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	555,169	0.000000	0.000000	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	1,168,008	0.000000	0.000000	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	223,497,552			9,883,956	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142011

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XIX			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	0	0		50.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
57.01	03630 ULTRA SOUND	0	0	0		57.01
58.00	05800 MRI	0	0	0		58.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.00	03950 SUBSTANCE ABUSE	0	0	0		76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699 LI THOTRI PSY	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0	0	0		90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/20/2016 2:03 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		32,020	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		32,020	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)		32,020	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)		16,530	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)		28,068,492	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)		28,068,492	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)		28,068,492	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)		876.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		14,490,033	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)		14,490,033	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142011		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
		Title XVIII		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	3,416,227	2,125	1,607.64	858	1,379,355	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					15,125,640	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					30,995,028	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)					1,139,814	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					920,999	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,060,813	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					28,934,215	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142011		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/20/2016 2:03 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,050,104	28,068,492	0.073039	0	0	90.00
91.00	Nursing School cost	0	28,068,492	0.000000	0	0	91.00
92.00	Allied health cost	0	28,068,492	0.000000	0	0	92.00
93.00	All other Medical Education	0	28,068,492	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/20/2016 2:03 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		32,020	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		32,020	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)		32,020	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)		951	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)		28,068,492	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)		28,068,492	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)		28,068,492	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)		876.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		833,637	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)		833,637	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142011		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
Date/Time Prepared: 5/20/2016 2:03 pm		Title XIX		Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	3,416,227	2,125	1,607.64	14	22,507		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)					1,617,788		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,473,932		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)					62,221		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					98,732		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					160,953		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,312,979		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142011		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/20/2016 2:03 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,050,104	28,068,492	0.073039	0	0	90.00
91.00	Nursing School cost	0	28,068,492	0.000000	0	0	91.00
92.00	Allied health cost	0	28,068,492	0.000000	0	0	92.00
93.00	All other Medical Education	0	28,068,492	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/20/2016 2:03 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		53,776,283		30.00
31.00	03100 INTENSIVE CARE UNIT		3,550,099		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.287239	719,855	206,770	50.00
53.00	05300 ANESTHESIOLOGY	0.012515	181,443	2,271	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.427207	1,850,396	790,502	54.00
56.00	05600 RADIOISOTOPE	0.314985	64,229	20,231	56.00
57.00	05700 CT SCAN	0.068469	1,542,252	105,596	57.00
57.01	03630 ULTRASOUND	0.134109	407,499	54,649	57.01
58.00	05800 MRI	0.069220	1,250	87	58.00
60.00	06000 LABORATORY	0.138859	12,639,418	1,755,097	60.00
65.00	06500 RESPIRATORY THERAPY	0.116313	26,027,385	3,027,323	65.00
66.00	06600 PHYSICAL THERAPY	0.439089	5,150,215	2,261,403	66.00
69.00	06900 ELECTROCARDIOLOGY	0.141186	573,212	80,930	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.308589	64,470	19,895	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.228406	10,136,409	2,315,217	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.455190	139,747	63,611	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.127570	29,887,722	3,812,777	73.00
74.00	07400 RENAL DIALYSIS	0.288091	2,002,257	576,832	74.00
76.00	03950 SUBSTANCE ABUSE	0.478008	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.492189	50,352	24,783	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.772125	9,929	7,666	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.497291	0	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		91,448,040	15,125,640	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)		91,448,040		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/20/2016 2:03 pm	
Cost Center Description		Title XIX	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		7,441,237	30.00
31.00	03100	INTENSIVE CARE UNIT		230,470	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.287239	45,784	50.00
53.00	05300	ANESTHESIOLOGY	0.012515	11,183	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.427207	134,446	54.00
56.00	05600	RADIOISOTOPE	0.314985	5,446	56.00
57.00	05700	CT SCAN	0.068469	205,225	57.00
57.01	03630	ULTRA SOUND	0.134109	70,196	57.01
58.00	05800	MRI	0.069220	0	58.00
60.00	06000	LABORATORY	0.138859	1,233,992	60.00
65.00	06500	RESPIRATORY THERAPY	0.116313	1,977,157	65.00
66.00	06600	PHYSICAL THERAPY	0.439089	666,476	66.00
69.00	06900	ELECTROCARDIOLOGY	0.141186	87,107	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.308589	5,777	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.228406	1,052,041	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.455190	6,902	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.127570	4,311,442	73.00
74.00	07400	RENAL DIALYSIS	0.288091	70,782	74.00
76.00	03950	SUBSTANCE ABUSE	0.478008	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.492189	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.772125	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0.497291	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		9,883,956	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		9,883,956	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/20/2016 2:03 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,430	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,792,846	2.00
3.00	PPS payments		2,177,449	3.00
4.00	Outlier payment (see instructions)		45,314	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)		1,430	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		11,208	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)		11,208	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)		11,208	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		9,778	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)		1,430	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)		2,222,763	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)		467,885	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)		1,756,308	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		329	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)		1,756,637	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,756,637	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)		83,065	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		53,992	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		81,550	36.00
37.00	Subtotal (see instructions)		1,810,629	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)		1,810,629	40.00
40.01	Sequestration adjustment (see instructions)		36,213	40.01
41.00	Interim payments		1,719,323	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		55,093	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: 142011

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

Worksheet E-1
Part I
Date/Time Prepared:
5/20/2016 2:03 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		23,922,872		1,719,323	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		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)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		23,922,872		1,719,323	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		508,917		55,093	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		24,431,789		1,774,416	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: 142011

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

Worksheet E-1
Part II
Date/Time Prepared:
5/20/2016 2:03 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,488	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	17,388	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	34,145	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	333,336,678	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part IV Date/Time Prepared: 5/20/2016 2:03 pm
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		23,027,471	1.00
2.00	Outlier Payments		4,098,464	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		27,125,935	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		0	5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)		0	6.00
7.00	Subtotal (see instructions)		27,125,935	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		27,125,935	9.00
10.00	Deductibles		70,516	10.00
11.00	Subtotal (line 9 minus line 10)		27,055,419	11.00
12.00	Coinsurance		2,644,325	12.00
13.00	Subtotal (line 11 minus line 12)		24,411,094	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		794,794	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		516,616	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		768,426	16.00
17.00	Subtotal (sum of lines 13 and 15)		24,927,710	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		2,687	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	21.50
21.99	Recovery of Accelerated Depreciation		0	21.99
22.00	Total amount payable to the provider (see instructions)		24,930,397	22.00
22.01	Sequestration adjustment (see instructions)		498,608	22.01
23.00	Interim payments		23,922,872	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 23 and 24)		508,917	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions)		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 5/20/2016 2:03 pm	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		7,441,237		8.00
9.00	Ancillary service charges		9,883,956	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		17,325,193	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		17,325,193	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		17,325,193	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet E-4 Date/Time Prepared: 5/20/2016 2:03 pm	
		Title XVII I	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			2.57	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			1.19	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-1.30	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.08	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.45	6.00
7.00	Enter the lesser of line 5 or line 6			0.08	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.14	0.31	0.45	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.02	0.06	0.08	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	0.02	0.06		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.08	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.03	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.04	0.02		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	0.04	0.02		17.00
18.00	Per resident amount	98,702.00	98,702.00		18.00
19.00	Approved amount for resident costs	3,948	1,974	5,922	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.37	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			5,922	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	17,388	0		26.00
27.00	Total Inpatient Days (see instructions)	34,145	34,145		27.00
28.00	Ratio of inpatient days to total inpatient days	0.509240	0.000000		28.00
29.00	Program direct GME amount	3,016	0		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		0		30.00
31.00	Net Program direct GME amount			3,016	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 142011	Period: From 01/01/2015 To 12/31/2015	Worksheet E-4 Date/Time Prepared: 5/20/2016 2:03 pm
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		3,901,134	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		30,995,028	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		30,995,028	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		3,794,276	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		3,794,276	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		34,789,304	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.890936	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.109064	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		3,016	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		2,687	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		329	50.00

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

Provider CCN: 142011

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

Worksheet G

Date/Time Prepared:
5/20/2016 2:03 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	10,089	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	20,628,034	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,635,965	0	0	0	6.00
7.00	Inventory	1,121,330	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	370,379	0	0	0	9.00
10.00	Due from other funds	-469,359	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	20,024,508	0	0	0	11.00
FIXED ASSETS						
12.00	Land	342,000	0	0	0	12.00
13.00	Land improvements	4,077,827	0	0	0	13.00
14.00	Accumulated depreciation	-2,199,124	0	0	0	14.00
15.00	Buildings	86,859,116	0	0	0	15.00
16.00	Accumulated depreciation	-71,041,805	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	2,119,028	0	0	0	19.00
20.00	Accumulated depreciation	-2,013,891	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	30,764,136	0	0	0	23.00
24.00	Accumulated depreciation	-26,200,374	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	22,706,913	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	246,764	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	246,764	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	42,978,185	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	220,261	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	47,950,249	0	0	0	43.00
44.00	Other current liabilities	11,153,139	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	59,323,649	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,958,765	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,958,765	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	62,282,414	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-19,304,229	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)	-19,304,229	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	42,978,185	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 142011

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

Worksheet G-1

Date/Time Prepared:
5/20/2016 2:03 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-13,640,871			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-5,663,358				2.00
3.00	Total (sum of line 1 and line 2)		-19,304,229			0	3.00
4.00	RECONCILING ITEM	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		-19,304,229			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-19,304,229			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	RECONCILING ITEM		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 142011

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/20/2016 2:03 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	101,505,441		101,505,441	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)	101,505,441		101,505,441	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	8,333,685		8,333,685	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)	8,333,685		8,333,685	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	109,839,126		109,839,126	17.00
18.00	Ancillary services	167,920,816	53,853,558	221,774,374	18.00
19.00	Outpatient services	0	1,706,838	1,706,838	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	CLINIC OP REVENUE	0	16,339	16,339	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	277,759,942	55,576,735	333,336,677	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		77,170,677		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		77,170,677		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 142011

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

Worksheet G-3

Date/Time Prepared:
5/20/2016 2:03 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	333,336,677	1.00
2.00	Less contractual allowances and discounts on patients' accounts	263,750,431	2.00
3.00	Net patient revenues (line 1 minus line 2)	69,586,246	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	77,170,677	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,584,431	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	405	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	340,430	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	1,062	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	INTERCOMPANY RENTAL	887,104	24.00
24.01	NET ASSETS RELEASED	14,878	24.01
24.02	OTHER REVENUE	677,194	24.02
25.00	Total other income (sum of lines 6-24)	1,921,073	25.00
26.00	Total (line 5 plus line 25)	-5,663,358	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)	-5,663,358	29.00