

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: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/23/2016 1:54 pm
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<b>PART I - COST REPORT STATUS</b>			
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: 5/23/2016	Time: 1:54 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ALTON MEMORIAL HOSPITAL ( 140002 ) 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			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	278,842	-11,241	-46,655	0	1.00
2.00 Subprovider - IPF	0	32,319	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
7.00 SKILLED NURSING FACILITY	0	4,419	0		0	7.00
200.00 Total	0	315,580	-11,241	-46,655	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: 140002		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 5/23/2016 1:51 pm		
1.00			2.00		3.00			4.00			
Hospital and Hospital Health Care Complex Address:											
1.00 Street: ONE MEMORIAL DRIVE			2.00 PO Box:								1.00
2.00 City: ALTON			State: IL		Zip Code: 62002-			County: MADISON			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	
Hospital and Hospital-Based Component Identification:											
3.00 Hospital											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)									2		21.00
Inpatient PPS Information											
22.00 Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.							Y	N		22.00	
22.01 Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)							Y	Y		22.01	
22.02 Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.							N	N		22.02	
22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.							N	N		22.03	
23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.								3		N	23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.				3,290	644	42	15	689	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: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/23/2016 1:51 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					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	Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00

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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
<b>Inpatient Psychiatric Facility PPS</b>						
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.			Y		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)			N	0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
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
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
<b>TEFRA Providers</b>						
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	
<b>Title V and XIX Services</b>						
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.				Y	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		XIX			
		1.00		2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N			96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		97.00
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N					105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N					106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N					108.00
		Physical		Speech		Respiratory	
		1.00		3.00		4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.					N	
						1.00	
						2.00	
						3.00	
<b>Miscellaneous Cost Reporting Information</b>							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2					118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	0		5,000		1,272,000	
						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					
119.00	DO NOT USE THIS LINE						
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
<b>Transplant Center Information</b>							
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					
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.						
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.						
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.						
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.						
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.						
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.						
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.						
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.						
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.						

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/23/2016 1:51 pm									
		1.00	2.00										
140.00	All Providers 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	269026	140.00									
		1.00	2.00	3.00									
141.00	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: BJC HEALTH SYSTEM	Contractor's Name: WPS		Contractor's Number: 05301		141.00							
142.00	Street: 4901 FOREST PARK AVENUE	PO Box:				142.00							
143.00	City: ST. LOUIS	State: MO		Zip Code: 63108		143.00							
				1.00									
144.00	Are provider based physicians' costs included in Worksheet A?	Y			144.00								
				1.00 2.00									
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y			145.00								
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00								
				1.00									
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N			147.00								
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N			148.00								
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N			149.00								
		Part A		Part B		Title V		Title XIX					
		1.00		2.00		3.00		4.00					
155.00	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)	N		N		N		N					
156.00	Hospital	N		N		N		N					
157.00	Subprovider - IPF	N		N		N		N					
158.00	Subprovider - IRF	N		N		N		N					
159.00	SUBPROVIDER	N		N		N		N					
159.00	SNF	N		N		N		N					
160.00	HOME HEALTH AGENCY	N		N		N		N					
161.00	CMHC	N		N		N		N					
								1.00					
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N			165.00								
		Name		County		State		Zip Code		CBSA		FTE/Campus	
		0		1.00		2.00		3.00		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)											0.00	
												1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act													
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y			167.00								
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0			168.00								
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)				168.01								
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.50			169.00								
		Beginni ng		Endi ng									
		1.00		2.00									
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2015		03/31/2015		170.00							

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/23/2016 1:51 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: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/23/2016 1:51 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		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	03/29/2016	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		Y	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: 140002

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/23/2016 1:51 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	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			Y	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	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.			Y	35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
<b>Cost Report Preparer Contact Information</b>					
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.	PAUL		BRADSHAW	41.00
42.00	Enter the employer/company name of the cost report preparer.	BJC HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-362-7419		PJB1541@BJC.ORG	43.00

		Part B		
		Date		
		4.00		
<b>PS&amp;R Data</b>				
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)	03/29/2016		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	
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

VOLUNTARY CONTACT INFORMATION

Provider CCN: 140002

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

Worksheet S-2  
Part V  
Date/Time Prepared:  
5/23/2016 1:51 pm

		1.00	
<b>Cost Report Preparer Contact Information</b>			
1.00	First Name	PAUL	1.00
2.00	Last Name	BRADSHAW	2.00
3.00	Title	REIMBURSEMENT MANAGER	3.00
4.00	Employer	BJC HEALTHCARE	4.00
5.00	Phone Number	(314)362-7419	5.00
6.00	E-mail Address	PJB1541@BJC.ORG	6.00
7.00	Department	BJC @ THE COMMONS	7.00
8.00	Mailing Address 1	MAILSTOP 90-67-808	8.00
9.00	Mailing Address 2	4249 CLAYTON AVE	9.00
10.00	City	ST. LOUIS	10.00
11.00	State	MO	11.00
12.00	Zip	63110	12.00
<b>Officer or Administrator of Provider Contact Information</b>			
13.00	First Name		13.00
14.00	Last Name		14.00
15.00	Title		15.00
16.00	Employer		16.00
17.00	Phone Number		17.00
18.00	E-mail Address		18.00
19.00	Department		19.00
20.00	Mailing Address 1		20.00
21.00	Mailing Address 2		21.00
22.00	City		22.00
23.00	State		23.00
24.00	Zip		24.00

HFS Supplemental Information		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part IX Date/Time Prepared: 5/23/2016 1:51 pm	
			Title V	Title XIX	
			1.00	2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	3.00
			Inpatient	Outpatient	
			1.00	2.00	
<b>CRITICAL ACCESS HOSPITALS</b>					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	5.00
			Title V	Title XIX	
			1.00	2.00	
<b>RCE DISALLOWANCE</b>					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	6.00
<b>PASS THROUGH COST</b>					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	7.00
<b>RHC</b>					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	8.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140002

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/23/2016 1:51 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	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	12	4,380	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		132	48,180	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	24	8,760		0	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)		176				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: 140002

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/23/2016 1:51 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)	9,744	1,630	21,294			1.00
2.00 HMO and other (see instructions)	3,201	2,647				2.00
3.00 HMO IPF Subprovider	171	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)	9,744	1,630	21,294			7.00
8.00 INTENSIVE CARE UNIT	1,205	403	2,625			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)	10,949	2,033	23,919	0.00	675.90	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	2,587	0	2,946	0.00	18.30	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	2,995	0	4,596	0.00	22.60	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	716.80	27.00
28.00 Observation Bed Days		0	1,404			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: 140002

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/23/2016 1:51 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,851	684	6,935	1.00
2.00 HMO and other (see instructions)			902	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	2,851	684	6,935	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	224	0	290	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140002		Period: From 01/01/2015 To 12/31/2015		Worksheet S-3 Part II Date/Time Prepared: 5/23/2016 1:51 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	40,140,392	0	40,140,392	1,481,817.00	27.09	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		174,777	0	174,777	1,277.00	136.87	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,253,040	0	1,253,040	46,149.00	27.15	9.00
10.00	Excluded area salaries (see instructions)		3,889,119	25,998	3,915,117	177,090.00	22.11	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor: Direct Patient Care		656,943	0	656,943	8,065.00	81.46	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		399,510	0	399,510	2,582.00	154.73	13.00
14.00	Home office salaries & wage-related costs		8,132,411	0	8,132,411	163,857.00	49.63	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		9,891,435	0	9,891,435			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,475,166	0	1,475,166			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		43,523	0	43,523			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	1,229,022	0	1,229,022	71,249.00	17.25	26.00
27.00	Administrative & General	5.00	2,781,456	0	2,781,456	69,859.00	39.82	27.00
28.00	Administrative & General under contract (see inst.)		648,474	0	648,474	5,555.00	116.74	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	777,152	0	777,152	30,079.00	25.84	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	943,530	0	943,530	76,081.00	12.40	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,479,527	0	1,479,527	84,038.00	17.61	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,068,648	0	1,068,648	31,151.00	34.31	38.00
39.00	Central Services and Supply	14.00	221,723	0	221,723	12,491.00	17.75	39.00
40.00	Pharmacy	15.00	1,696,961	0	1,696,961	42,365.00	40.06	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140002

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/23/2016 1:51 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 445,552	0	445,552	24,053.00	18.52	41.00
42.00	Social Service	17.00 899,933	0	899,933	28,214.00	31.90	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140002

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/23/2016 1:51 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	42,268,393	0	42,268,393	1,571,410.00	26.90	1.00
2.00	Excluded area salaries (see instructions)	5,142,159	25,998	5,168,157	223,239.00	23.15	2.00
3.00	Subtotal salaries (line 1 minus line 2)	37,126,234	-25,998	37,100,236	1,348,171.00	27.52	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,188,864	0	9,188,864	174,504.00	52.66	4.00
5.00	Subtotal wage-related costs (see inst.)	9,934,958	0	9,934,958	0.00	26.78	5.00
6.00	Total (sum of lines 3 thru 5)	56,250,056	-25,998	56,224,058	1,522,675.00	36.92	6.00
7.00	Total overhead cost (see instructions)	12,191,978	0	12,191,978	475,135.00	25.66	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part IV Date/Time Prepared: 5/23/2016 1:51 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions		1,763,879	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		815,390	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		4,791,856	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		179,543	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		25,579	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		222,439	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		482,598	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		2,889,358	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		5,539	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		233,943	23.00
24.00	<b>Total Wage Related cost (Sum of lines 1 -23)</b>		<b>11,410,124</b>	<b>24.00</b>
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

WAGE INDEX PENSION COST SCHEDULE		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part IV Exhibit 3 Date/Time Prepared: 5/23/2016 1:51 pm
				1.00
1.00	Step 1: Determine the 3-Year Averaging Period Wage Index FY ending.			2019 1.00
				From To
				1.00 2.00
2.00	Provider cost reporting period used for Wage Index year shown on Line 1.			01/01/2015 12/31/2015 2.00
3.00	End of the 3-year averaging period (Final date from cost reporting period shown on Line 2.)			12/31/2015 3.00
4.00	Beginning of the 3-year averaging period (Subtract 36 months from End date shown on Line 3)			01/01/2013 4.00
Step 2: Adjust Averaging Period for a New Plan (See Instructions) (Leave this section blank if the provider has not elected to use an adjusted averaging period)				
5.00	Effective date of pension plan			5.00
6.00	First day of the provider cost reporting period containing the pension plan effective date			6.00
Step 3: Average Pension Contribution During the Averaging Period				
7.00	Beginning date of averaging period from Line 4 or Line 6			01/01/2013 7.00
8.00	Ending date of averaging period from Line 3			12/31/2015 8.00
				Deposit Date Contributions
				1.00 2.00
9.00	Enter provider contributions made during the averaging period shown on lines 7 & 8. Add additional lines as necessary if more than 15 contributions are made during the cost reporting period. (Data may be grouped within the averaging period to agree with documentation records (enter beginning date of grouped date range))			9.00
9.01				01/01/2013 122,115,532 9.01
9.02				01/01/2014 109,100,000 9.02
9.03				01/01/2015 125,250,000 9.03
				1.00
10.00	Total Number of Months Included in Averaging Period			36 10.00
11.00	Total Contributions Made During Averaging Period			356,465,532 11.00
12.00	Average Monthly Contribution. (Line 11 divided by line 10)			9,901,820 12.00
13.00	Number of Months in Provider Cost Reporting Period shown on Line 2			12 13.00
14.00	Average Pension Contributions (Line 12 multiplied by Line 13)			118,821,840 14.00
Step 4: Total Pension Cost for Wage Index (If the Wage Index FY shown on Line 1 is after 2022, enter "0" on Lines 15 and 16.)				
15.00	Annual Prefunding Installment from Line 8 of Pension Prefunding Worksheet, if applicable (see instructions)			4,233,831 15.00
16.00	Reportable Prefunding Installment (Line 15 multiplied by Line 13/12)			4,233,831 16.00
17.00	Total Pension Cost for Wage Index (Line 14 + Line 16)			123,055,671 17.00
				Prepared By Date
				1.00 2.00
100.00	Prepared By and Date Prepared			CASSANDRA CUSICK 05/11/2016 100.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part V Date/Time Prepared: 5/23/2016 1:51 pm
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	Subprovider - IPF		0	0 3.00
4.00	Subprovider - IRF			0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF		0	0 8.00
9.00	Hospital-Based NF			0 9.00
10.00	Hospital-Based OLTC			0 10.00
11.00	Hospital-Based HHA			0 11.00
12.00	Separately Certified ASC			0 12.00
13.00	Hospital-Based Hospice			0 13.00
14.00	Hospital-Based Health Clinic RHC			0 14.00
15.00	Hospital-Based Health Clinic FQHC			0 15.00
16.00	Hospital-Based-CMHC			0 16.00
17.00	Renal Dialysis		0	0 17.00
18.00	Other		0	0 18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140002

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

Worksheet S-7

Date/Time Prepared:  
5/23/2016 1:51 pm

		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	31	0	31 13.00
14.00		RUA	24	0	24 14.00
15.00		RVC	77	0	77 15.00
16.00		RVB	115	0	115 16.00
17.00		RVA	503	0	503 17.00
18.00		RHC	132	0	132 18.00
19.00		RHB	161	0	161 19.00
20.00		RHA	1,189	0	1,189 20.00
21.00		RMC	50	0	50 21.00
22.00		RMB	57	0	57 22.00
23.00		RMA	171	0	171 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	14	0	14 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	21	0	21 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	26	0	26 33.00
34.00		HC1	18	0	18 34.00
35.00		HB2	14	0	14 35.00
36.00		HB1	79	0	79 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	4	0	4 38.00
39.00		LD2	7	0	7 39.00
40.00		LD1	6	0	6 40.00
41.00		LC2	13	0	13 41.00
42.00		LC1	6	0	6 42.00
43.00		LB2	37	0	37 43.00
44.00		LB1	13	0	13 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	4	0	4 47.00
48.00		CD1	3	0	3 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	6	0	6 50.00
51.00		CB2	3	0	3 51.00
52.00		CB1	24	0	24 52.00
53.00		CA2	15	0	15 53.00
54.00		CA1	114	0	114 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140002

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

Worksheet S-7

Date/Time Prepared:  
5/23/2016 1:51 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	25	0	25	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	7	0	7	78.00
199.00		AAA	26	0	26	199.00
200.00	TOTAL		2,995	0	2,995	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).		41180	41180	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		1,253,040	36.87	N	202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		3,398,853			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 5/23/2016 1:51 pm
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				1.00		
<b>Uncompensated and indigent care cost computation</b>						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.237584	1.00	
<b>Medicaid (see instructions for each line)</b>						
2.00	Net revenue from Medicaid			10,620,172	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			6,338,661	5.00	
6.00	Medicaid charges			72,422,524	6.00	
7.00	Medicaid cost (line 1 times line 6)			17,206,433	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			247,600	8.00	
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>						
9.00	Net revenue from stand-alone SCHIP			0	9.00	
10.00	Stand-alone SCHIP charges			0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
<b>Other state or local government indigent care program (see instructions for each line)</b>						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
<b>Uncompensated care (see instructions for each line)</b>						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			9,191	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			247,600	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility			5,954,499	579,695	6,534,194
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)			1,414,694	137,726	1,552,420
22.00	Partial payment by patients approved for charity care			93,443	90,176	183,619
23.00	Cost of charity care (line 21 minus line 22)			1,321,251	47,550	1,368,801
				1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit					0
26.00	Total bad debt expense for the entire hospital complex (see instructions)					7,393,827
27.00	Medicare bad debts for the entire hospital complex (see instructions)					971,359
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)					6,422,468
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)					1,525,876
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)					2,894,677
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)					3,142,277

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140002

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

Worksheet A  
Date/Time Prepared:  
5/23/2016 1:51 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		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		0	4,702,922	4,702,922	1.00	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	5,277,651	5,277,651	2.00	
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	270,854	721,208	992,062	-1,105	990,957	4.00
4.03	00401	ADMINISTRATIVE	958,168	336,061	1,294,229	-10,509	1,283,720	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	2,781,456	32,045,473	34,826,929	-8,200,946	26,625,983	5.00
7.00	00700	OPERATION OF PLANT	777,152	2,253,509	3,030,661	-46,002	2,984,659	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	361,230	361,230	-196	361,034	8.00
9.00	00900	HOUSEKEEPING	943,530	479,187	1,422,717	-310	1,422,407	9.00
10.00	01000	DIETARY	0	2,434,474	2,434,474	-15,565	2,418,909	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,068,648	451,968	1,520,616	-78,457	1,442,159	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	221,723	211,340	433,063	-222,035	211,028	14.00
15.00	01500	PHARMACY	1,696,961	10,219,873	11,916,834	-167,355	11,749,479	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	445,552	295,346	740,898	-747	740,151	16.00
17.00	01700	SOCIAL SERVICE	899,933	319,580	1,219,513	-2,381	1,217,132	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	8,060,496	5,077,503	13,137,999	-400,078	12,737,921	30.00
31.00	03100	INTENSIVE CARE UNIT	1,789,830	1,061,391	2,851,221	-154,711	2,696,510	31.00
40.00	04000	SUBPROVIDER - I/PF	1,124,115	397,898	1,522,013	-8,003	1,514,010	40.00
44.00	04400	SKILLED NURSING FACILITY	1,253,040	490,289	1,743,329	-32,806	1,710,523	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	2,119,818	10,881,361	13,001,179	-7,691,465	5,309,714	50.00
51.00	05100	RECOVERY ROOM	505,277	215,448	720,725	9,292	730,017	51.00
53.00	05300	ANESTHESIOLOGY	30,033	459,510	489,543	-189,610	299,933	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,214,099	1,408,239	3,622,338	-486,187	3,136,151	54.00
56.00	05600	RADIOISOTOPE	188,698	265,182	453,880	3,185	457,065	56.00
57.00	05700	CT SCAN	246,678	272,042	518,720	-25,559	493,161	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	187,562	463,489	651,051	-45,308	605,743	58.00
59.00	05900	CARDIAC CATHETERIZATION	551,628	1,836,003	2,387,631	-1,523,816	863,815	59.00
60.00	06000	LABORATORY	1,357,941	2,201,123	3,559,064	-477,265	3,081,799	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	229,370	738,841	968,211	351,348	1,319,559	63.00
65.00	06500	RESPIRATORY THERAPY	742,421	430,682	1,173,103	-56,804	1,116,299	65.00
66.00	06600	PHYSICAL THERAPY	1,036,779	427,408	1,464,187	-57,114	1,407,073	66.00
67.00	06700	OCCUPATIONAL THERAPY	216,559	57,309	273,868	7,226	281,094	67.00
68.00	06800	SPEECH PATHOLOGY	151,229	40,550	191,779	5,862	197,641	68.00
69.00	06900	ELECTROCARDIOLOGY	774,837	482,083	1,256,920	-1,501	1,255,419	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,441,327	2,441,327	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	7,693,715	7,693,715	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	406,835	406,835	-17,190	389,645	74.00
76.00	03020	ONCOLOGY	655,218	1,464,416	2,119,634	-46,018	2,073,616	76.00
76.01	03340	GASTROINTESTINAL SERVICES	649,818	679,700	1,329,518	-273,499	1,056,019	76.01
76.02	03550	OP PSYCH	346,728	131,024	477,752	-23,003	454,749	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	259,738	259,738	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	2,879,237	1,395,833	4,275,070	-280,342	3,994,728	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	1,915,096	1,222,739	3,137,835	-211,661	2,926,174	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,290,484	82,636,147	121,926,631	4,718	121,931,349	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,623	69,185	96,808	-1,865	94,943	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	10,178	5,271	15,449	-304	15,145	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	196,513	793,736	990,249	-1,489	988,760	193.01
193.02	19302	MEDICAL OFFICE BUILDING	186,468	499,196	685,664	0	685,664	193.02
193.03	19303	HOME CARE PHARMACY	357,420	2,942,414	3,299,834	-1,060	3,298,774	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	0	0	0	0	193.06
193.07	19307	POB 2	71,706	433,396	505,102	0	505,102	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	46,011	46,011	0	46,011	193.09
200.00		TOTAL (SUM OF LINES 118-199)	40,140,392	87,425,356	127,565,748	0	127,565,748	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140002

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

Worksheet A  
Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	4,702,922	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	5,277,651	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,036	984,921	4.00
4.03	00401	ADMINISTRATIVE	0	1,283,720	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	-6,664,908	19,961,075	5.00
7.00	00700	OPERATION OF PLANT	-20,736	2,963,923	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	361,034	8.00
9.00	00900	HOUSEKEEPING	0	1,422,407	9.00
10.00	01000	DIETARY	-27,203	2,391,706	10.00
11.00	01100	CAFETERIA	-528,845	-528,845	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,442,159	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	211,028	14.00
15.00	01500	PHARMACY	-3,236	11,746,243	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-130,241	609,910	16.00
17.00	01700	SOCIAL SERVICE	0	1,217,132	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-1,357,410	11,380,511	30.00
31.00	03100	INTENSIVE CARE UNIT	-241,992	2,454,518	31.00
40.00	04000	SUBPROVIDER - IPF	-54,000	1,460,010	40.00
44.00	04400	SKILLED NURSING FACILITY	-74	1,710,449	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-355,447	4,954,267	50.00
51.00	05100	RECOVERY ROOM	0	730,017	51.00
53.00	05300	ANESTHESIOLOGY	0	299,933	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-7,949	3,128,202	54.00
56.00	05600	RADIOISOTOPE	0	457,065	56.00
57.00	05700	CT SCAN	0	493,161	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-296,585	309,158	58.00
59.00	05900	CARDIAC CATHETERIZATION	-32	863,783	59.00
60.00	06000	LABORATORY	18,650	3,100,449	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,319,559	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,116,299	65.00
66.00	06600	PHYSICAL THERAPY	-88	1,406,985	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	281,094	67.00
68.00	06800	SPEECH PATHOLOGY	0	197,641	68.00
69.00	06900	ELECTROCARDIOLOGY	-19,267	1,236,152	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,441,327	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	7,693,715	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	389,645	74.00
76.00	03020	ONCOLOGY	-1,151,917	921,699	76.00
76.01	03340	GASTROINTESTINAL SERVICES	0	1,056,019	76.01
76.02	03550	OP PSYCH	0	454,749	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	259,738	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	EMERGENCY	-37,752	3,956,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	-72,674	2,853,500	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-10,957,742	110,973,607	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	94,943	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	192.01
193.00	19300	NONPAID WORKERS	0	15,145	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	988,760	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	685,664	193.02
193.03	19303	HOME CARE PHARMACY	0	3,298,774	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	193.05
193.06	19306	VACANT SPACE	0	0	193.06
193.07	19307	POB 2	0	505,102	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	193.08
193.09	19309	COFFEE BAR	0	46,011	193.09
200.00		TOTAL (SUM OF LINES 118-199)	-10,957,742	116,608,006	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 140002

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

Worksheet Non-CMS W  
Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00 NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00 OTHER CAPITAL RELATED COSTS	00300		3.00
4.00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
4.03 ADMIN TTING	00401		4.03
5.00 ADMINI STRATIVE & GENERAL	00500		5.00
7.00 OPERATION OF PLANT	00700		7.00
8.00 LAUNDRY & LINEN SERVICE	00800		8.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
11.00 CAFETERIA	01100		11.00
13.00 NURSING ADMINI STRATION	01300		13.00
14.00 CENTRAL SERVICES & SUPPLY	01400		14.00
15.00 PHARMACY	01500		15.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
17.00 SOCIAL SERVICE	01700		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
40.00 SUBPROVIDER - IPF	04000		40.00
44.00 SKILLED NURSING FACILITY	04400		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 OPERATING ROOM	05000		50.00
51.00 RECOVERY ROOM	05100		51.00
53.00 ANESTHESIOLOGY	05300		53.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00 RADIOISOTOPE	05600		56.00
57.00 CT SCAN	05700		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00 CARDIAC CATHETERIZATION	05900		59.00
60.00 LABORATORY	06000		60.00
63.00 BLOOD STORING, PROCESSING & TRANS.	06300		63.00
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
67.00 OCCUPATIONAL THERAPY	06700		67.00
68.00 SPEECH PATHOLOGY	06800		68.00
69.00 ELECTROCARDIOLOGY	06900		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
74.00 RENAL DIALYSIS	07400		74.00
76.00 ONCOLOGY	03020	ACUPUNCTURE	76.00
76.01 GASTRO INTESTINAL SERVICES	03340	GASTRO INTESTINAL SERVICES	76.01
76.02 OP PSYCH	03550	PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES	76.02
76.98 HYPERBARIC OXYGEN THERAPY	07698	HYPERBARIC OXYGEN THERAPY	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>			
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00 AMBULANCE SERVICES	09500		95.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00 PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01 TWIN RIVERS MRI	19201		192.01
193.00 NONPAID WORKERS	19300		193.00
193.01 PHYSICIAN/PUBLIC RELATIONS	19301		193.01
193.02 MEDICAL OFFICE BUILDING	19302		193.02
193.03 HOME CARE PHARMACY	19303		193.03
193.04 MANAGEMENT SERVICES	19304		193.04
193.05 EUNICE SMITH NURSING HOME	19305		193.05
193.06 VACANT SPACE	19306		193.06
193.07 POB 2	19307		193.07
193.08 NON REIMBURSABLE MEALS	19308		193.08
193.09 COFFEE BAR	19309		193.09
200.00 TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140002

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

Worksheet A-6

Date/Time Prepared:  
5/23/2016 1:51 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - RECLASS DEPRECIATION</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	4,599,548	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	5,223,126	2.00
			0	9,822,674	
<b>B - RECLASS MEDICAL SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,135,042	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
			0	10,135,042	
<b>C - TO RECLASS LAB ADMIN</b>					
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	185,154	171,254	1.00
			185,154	171,254	
<b>D - TO RECLASS DIRECTOR'S EXPENSE</b>					
1.00	RECOVERY ROOM	51.00	20,144	1,541	1.00
2.00	ANESTHESIOLOGY	53.00	34,661	2,652	2.00
3.00	RADIOISOTOPE	56.00	4,482	343	3.00
4.00	OCCUPATIONAL THERAPY	67.00	13,810	1,056	4.00
5.00	SPEECH PATHOLOGY	68.00	7,487	573	5.00
6.00	ELECTROCARDIOLOGY	69.00	77,944	5,963	6.00
7.00	CT SCAN	57.00	39,706	3,037	7.00
8.00	GASTROINTESTINAL SERVICES	76.01	42,108	3,222	8.00
9.00	AMBULANCE SERVICES	95.00	25,998	1,989	9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	5,760	441	10.00
			272,100	20,817	
<b>E - TO RECLASS HYPERBARIC OXYGEN EXPENSE</b>					
1.00	HYPERBARIC OXYGEN THERAPY	76.98	2,218	257,520	1.00
			2,218	257,520	
<b>F - TO RECLASS DEPRECIATION DEPT EXPENSE</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,779,627	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
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

Provider CCN: 140002

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

Worksheet A-6

Date/Time Prepared:  
5/23/2016 1:51 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
			0	1,779,627		
<b>G - TO RECLASS PROPERTY INSURANCE</b>						
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	157,899		1.00
			0	157,899		
<b>H - TO RECLASS MEDICAL IMPLANTS</b>						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	7,693,715		1.00
			0	7,693,715		
500.00	Grand Total: Increases		459,472	30,038,548		500.00

RECLASSIFICATIONS

Provider CCN: 140002

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

Worksheet A-6  
Date/Time Prepared:  
5/23/2016 1:51 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - RECLASS DEPRECIATION</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,822,674	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	9,822,674			
<b>B - RECLASS MEDICAL SUPPLIES</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	179,879	0		1.00
2.00	PHARMACY	15.00	0	162,534	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	333,811	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	94,417	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	7,844	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	24,998	0		6.00
7.00	OPERATING ROOM	50.00	0	7,112,216	0		7.00
8.00	RECOVERY ROOM	51.00	0	11,999	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	159,510	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	21,389	0		10.00
11.00	RADIOISOTOPE	56.00	0	732	0		11.00
12.00	CT SCAN	57.00	0	68,302	0		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	1,446,712	0		13.00
14.00	LABORATORY	60.00	0	5,933	0		14.00
15.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	1,027	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	1,789	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	11,143	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	3,591	0		18.00
19.00	SPEECH PATHOLOGY	68.00	0	2,198	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	8,338	0		20.00
21.00	RENAL DIALYSIS	74.00	0	17,190	0		21.00
22.00	ONCOLOGY	76.00	0	42,787	0		22.00
23.00	GASTROINTESTINAL SERVICES	76.01	0	192,930	0		23.00
24.00	OP PSYCH	76.02	0	336	0		24.00
25.00	EMERGENCY	91.00	0	184,767	0		25.00
26.00	AMBULANCE SERVICES	95.00	0	38,442	0		26.00
27.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	228	0		27.00
	0		0	10,135,042			
<b>C - TO RECLASS LAB ADMIN</b>							
1.00	LABORATORY	60.00	185,154	171,254	0		1.00
	0		185,154	171,254			
<b>D - TO RECLASS DIRECTOR'S EXPENSE</b>							
1.00	OPERATING ROOM	50.00	96,913	7,415	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	49,948	3,821	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	46,299	3,541	0		3.00
4.00	RESPIRATORY THERAPY	65.00	31,645	2,422	0		4.00
5.00	PHYSICAL THERAPY	66.00	21,297	1,629	0		5.00
6.00	EMERGENCY	91.00	25,998	1,989	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	0		272,100	20,817			
<b>E - TO RECLASS HYPERBARIC OXYGEN EXPENSE</b>							
1.00	OPERATING ROOM	50.00	2,218	257,520	0		1.00
	0		2,218	257,520			
<b>F - TO RECLASS DEPRECIATION DEPT EXPENSE</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,105	0		1.00
2.00	ADMINISTRATIVE	4.03	0	10,509	0		2.00
3.00	OPERATION OF PLANT	7.00	0	46,002	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	196	0		4.00
5.00	HOUSEKEEPING	9.00	0	310	0		5.00
6.00	DIETARY	10.00	0	15,565	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	78,457	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	42,156	0		8.00
9.00	PHARMACY	15.00	0	4,821	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	747	0		10.00
11.00	SOCIAL SERVICE	17.00	0	2,381	0		11.00
12.00	ADULTS & PEDIATRICS	30.00	0	66,267	0		12.00
13.00	INTENSIVE CARE UNIT	31.00	0	60,294	0		13.00
14.00	SUBPROVIDER - IPF	40.00	0	159	0		14.00
15.00	SKILLED NURSING FACILITY	44.00	0	7,808	0		15.00
16.00	OPERATING ROOM	50.00	0	215,183	0		16.00
17.00	RECOVERY ROOM	51.00	0	394	0		17.00
18.00	ANESTHESIOLOGY	53.00	0	67,413	0		18.00
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	411,029	0		19.00
20.00	RADIOISOTOPE	56.00	0	908	0		20.00

Decreases								
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
21.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	51,281	0		21.00	
22.00	CARDIAC CATHETERIZATION	59.00	0	27,264	0		22.00	
23.00	LABORATORY	60.00	0	114,924	0		23.00	
24.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	4,033	0		24.00	
25.00	RESPIRATORY THERAPY	65.00	0	20,948	0		25.00	
26.00	PHYSICAL THERAPY	66.00	0	23,045	0		26.00	
27.00	OCCUPATIONAL THERAPY	67.00	0	4,049	0		27.00	
28.00	ELECTROCARDIOLOGY	69.00	0	77,070	0		28.00	
29.00	ONCOLOGY	76.00	0	3,231	0		29.00	
30.00	GASTRO INTESTINAL SERVICES	76.01	0	125,899	0		30.00	
31.00	OP PSYCH	76.02	0	22,667	0		31.00	
32.00	EMERGENCY	91.00	0	67,588	0		32.00	
33.00	AMBULANCE SERVICES	95.00	0	201,206	0		33.00	
34.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	1,865	0		34.00	
35.00	NONPAID WORKERS	193.00	0	304	0		35.00	
36.00	PHYSICIAN/PUBLIC RELATIONS	193.01	0	1,489	0		36.00	
37.00	HOME CARE PHARMACY	193.03	0	1,060	0		37.00	
			0	1,779,627				
G - TO RECLASS PROPERTY INSURANCE								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	157,899	12		1.00	
			0	157,899				
H - TO RECLASS MEDICAL IMPLANTS								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,693,715	0		1.00	
			0	7,693,715				
500.00	Grand Total: Decreases		459,472	30,038,548			500.00	

RECLASSIFICATIONS

Provider CCN: 140002

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

Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
5/23/2016 1:51 pm

Increases					Decreases				
Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
<b>A - RECLASS DEPRECIATION</b>									
1.00	NEW CAP REL	1.00	0	4,599,548	ADMINISTRATIVE & GENERAL	5.00	0	9,822,674	1.00
2.00	COSTS-BLDG & FIXT	2.00	0	5,223,126		0.00	0	0	2.00
	NEW CAP REL								
	COSTS-MVBLE EQUIP		0	9,822,674			0	9,822,674	
<b>B - RECLASS MEDICAL SUPPLIES</b>									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,135,042	CENTRAL SERVICES & SUPPLY	14.00	0	179,879	1.00
2.00		0.00	0	0	PHARMACY	15.00	0	162,534	2.00
3.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	333,811	3.00
4.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	94,417	4.00
5.00		0.00	0	0	SUBPROVIDER - I/PF	40.00	0	7,844	5.00
6.00		0.00	0	0	SKILLED NURSING FACILITY	44.00	0	24,998	6.00
7.00		0.00	0	0	OPERATING ROOM	50.00	0	7,112,216	7.00
8.00		0.00	0	0	RECOVERY ROOM	51.00	0	11,999	8.00
9.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	159,510	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	21,389	10.00
11.00		0.00	0	0	RADIOISOTOPE	56.00	0	732	11.00
12.00		0.00	0	0	CT SCAN	57.00	0	68,302	12.00
13.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	1,446,712	13.00
14.00		0.00	0	0	LABORATORY	60.00	0	5,933	14.00
15.00		0.00	0	0	BLOOD STORAGE, PROCESSING & TRANS.	63.00	0	1,027	15.00
16.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	1,789	16.00
17.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	11,143	17.00
18.00		0.00	0	0	OCCUPATIONAL THERAPY	67.00	0	3,591	18.00
19.00		0.00	0	0	SPEECH PATHOLOGY	68.00	0	2,198	19.00
20.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	8,338	20.00
21.00		0.00	0	0	RENAL DIALYSIS	74.00	0	17,190	21.00
22.00		0.00	0	0	ONCOLOGY	76.00	0	42,787	22.00
23.00		0.00	0	0	GASTROINTESTINAL SERVICES	76.01	0	192,930	23.00
24.00		0.00	0	0	OP PSYCH	76.02	0	336	24.00
25.00		0.00	0	0	EMERGENCY	91.00	0	184,767	25.00
26.00		0.00	0	0	AMBULANCE SERVICES	95.00	0	38,442	26.00
27.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	228	27.00
			0	10,135,042			0	10,135,042	
<b>C - TO RECLASS LAB ADMIN</b>									
1.00	BLOOD STORAGE, PROCESSING & TRANS.	63.00	185,154	171,254	LABORATORY	60.00	185,154	171,254	1.00
			185,154	171,254			185,154	171,254	
<b>D - TO RECLASS DIRECTOR'S EXPENSE</b>									
1.00	RECOVERY ROOM	51.00	20,144	1,541	OPERATING ROOM	50.00	96,913	7,415	1.00
2.00	ANESTHESIOLOGY	53.00	34,661	2,652	RADIOLOGY-DIAGNOSTIC	54.00	49,948	3,821	2.00
3.00	RADIOISOTOPE	56.00	4,482	343	CARDIAC CATHETERIZATION	59.00	46,299	3,541	3.00
4.00	OCCUPATIONAL THERAPY	67.00	13,810	1,056	RESPIRATORY THERAPY	65.00	31,645	2,422	4.00
5.00	SPEECH PATHOLOGY	68.00	7,487	573	PHYSICAL THERAPY	66.00	21,297	1,629	5.00
6.00	ELECTROCARDIOLOGY	69.00	77,944	5,963	EMERGENCY	91.00	25,998	1,989	6.00
7.00	CT SCAN	57.00	39,706	3,037		0.00	0	0	7.00
8.00	GASTROINTESTINAL SERVICES	76.01	42,108	3,222		0.00	0	0	8.00
9.00	AMBULANCE SERVICES	95.00	25,998	1,989		0.00	0	0	9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	5,760	441		0.00	0	0	10.00
			272,100	20,817			272,100	20,817	
<b>E - TO RECLASS HYPERBARIC OXYGEN EXPENSE</b>									
1.00	HYPERBARIC OXYGEN THERAPY	76.98	2,218	257,520	OPERATING ROOM	50.00	2,218	257,520	1.00
			2,218	257,520			2,218	257,520	
<b>F - TO RECLASS DEPRECIATION DEPT EXPENSE</b>									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,779,627	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,105	1.00
2.00		0.00	0	0	ADMINITTING	4.03	0	10,509	2.00
3.00		0.00	0	0	OPERATION OF PLANT	7.00	0	46,002	3.00
4.00		0.00	0	0	LAUNDRY & LINEN SERVICE	8.00	0	196	4.00
5.00		0.00	0	0	HOUSEKEEPING	9.00	0	310	5.00
6.00		0.00	0	0	DIETARY	10.00	0	15,565	6.00
7.00		0.00	0	0	NURSING	13.00	0	78,457	7.00
					ADMINISTRATION				

RECLASSIFICATIONS

Provider CCN: 140002

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

Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
5/23/2016 1:51 pm

	Increases				Decreases					
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
8.00		0.00	0		0 CENTRAL SERVICES & SUPPLY	14.00	0	42,156	8.00	
9.00		0.00	0		0 PHARMACY	15.00	0	4,821	9.00	
10.00		0.00	0		0 MEDICAL RECORDS & LIBRARY	16.00	0	747	10.00	
11.00		0.00	0		0 SOCIAL SERVICE	17.00	0	2,381	11.00	
12.00		0.00	0		0 ADULTS & PEDIATRICS	30.00	0	66,267	12.00	
13.00		0.00	0		0 INTENSIVE CARE UNIT	31.00	0	60,294	13.00	
14.00		0.00	0		0 SUBPROVIDER - IPF	40.00	0	159	14.00	
15.00		0.00	0		0 SKILLED NURSING FACILITY	44.00	0	7,808	15.00	
16.00		0.00	0		0 OPERATING ROOM	50.00	0	215,183	16.00	
17.00		0.00	0		0 RECOVERY ROOM	51.00	0	394	17.00	
18.00		0.00	0		0 ANESTHESIOLOGY	53.00	0	67,413	18.00	
19.00		0.00	0		0 RADIOLOGY-DIAGNOSTIC	54.00	0	411,029	19.00	
20.00		0.00	0		0 RADIOISOTOPE	56.00	0	908	20.00	
21.00		0.00	0		0 MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	51,281	21.00	
22.00		0.00	0		0 CARDIAC CATHETERIZATION	59.00	0	27,264	22.00	
23.00		0.00	0		0 LABORATORY	60.00	0	114,924	23.00	
24.00		0.00	0		0 BLOOD STORAGE, PROCESSING & TRANS.	63.00	0	4,033	24.00	
25.00		0.00	0		0 RESPIRATORY THERAPY	65.00	0	20,948	25.00	
26.00		0.00	0		0 PHYSICAL THERAPY	66.00	0	23,045	26.00	
27.00		0.00	0		0 OCCUPATIONAL THERAPY	67.00	0	4,049	27.00	
28.00		0.00	0		0 ELECTROCARDIOLOGY	69.00	0	77,070	28.00	
29.00		0.00	0		0 ONCOLOGY	76.00	0	3,231	29.00	
30.00		0.00	0		0 GASTROINTESTINAL SERVICES	76.01	0	125,899	30.00	
31.00		0.00	0		0 OP PSYCH	76.02	0	22,667	31.00	
32.00		0.00	0		0 EMERGENCY	91.00	0	67,588	32.00	
33.00		0.00	0		0 AMBULANCE SERVICES	95.00	0	201,206	33.00	
34.00		0.00	0		0 GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	1,865	34.00	
35.00		0.00	0		0 NONPAID WORKERS	193.00	0	304	35.00	
36.00		0.00	0		0 PHYSICIAN/PUBLIC RELATIONS	193.01	0	1,489	36.00	
37.00		0.00	0		0 HOME CARE PHARMACY	193.03	0	1,060	37.00	
				0	1,779,627			0	1,779,627	
G - TO RECLASS PROPERTY INSURANCE										
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	157,899	ADMINISTRATIVE & GENERAL	5.00	0	157,899	1.00	
				0	157,899			0	157,899	
H - TO RECLASS MEDICAL IMPLANTS										
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	7,693,715	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,693,715	1.00	
				0	7,693,715			0	7,693,715	
500.00	Grand Total: Increases		459,472	30,038,548	Grand Total: Decreases		459,472	30,038,548	500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140002

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/23/2016 1:51 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	177,168	0	0	0	1.00
2.00	Land Improvements	5,959,132	0	0	201,536	2.00
3.00	Buildings and Fixtures	64,627,498	2,916,941	0	457,391	3.00
4.00	Building Improvements	16,896,376	173,500	0	370,189	4.00
5.00	Fixed Equipment	34,031,579	3,672,721	0	1,166,046	5.00
6.00	Movable Equipment	54,274,317	7,796,051	0	668,050	6.00
7.00	HIT designated Assets	3,884,878	1,308,692	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	179,850,948	15,867,905	0	2,863,212	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	179,850,948	15,867,905	0	2,863,212	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	177,168	0			1.00
2.00	Land Improvements	5,757,596	0			2.00
3.00	Buildings and Fixtures	67,087,048	0			3.00
4.00	Building Improvements	16,699,687	0			4.00
5.00	Fixed Equipment	36,538,254	0			5.00
6.00	Movable Equipment	61,402,318	0			6.00
7.00	HIT designated Assets	5,193,570	0			7.00
8.00	Subtotal (sum of lines 1-7)	192,855,641	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	192,855,641	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140002

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/23/2016 1:51 pm

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140002

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	126,259,753	0	126,259,753	0.654685	103,374	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	66,595,888	0	66,595,888	0.345315	54,525	2.00
3.00	Total (sum of lines 1-2)	192,855,641	0	192,855,641	1.000000	157,899	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	103,374	4,599,548	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	54,525	5,223,126	0	2.00
3.00	Total (sum of lines 1-2)	0	0	157,899	9,822,674	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	103,374	0	0	4,702,922	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	54,525	0	0	5,277,651	2.00
3.00	Total (sum of lines 1-2)	0	157,899	0	0	9,980,573	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140002

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

Worksheet A-8

Date/Time Prepared:  
5/23/2016 1:51 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-550	OPERATION OF PLANT	7.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-3,401,755			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	-3,151,677			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-528,845	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts		0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0	0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			OADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.00 ASSOCIATION DUES	A	-39,300	ADMINISTRATIVE & GENERAL		5.00	0 33.00
33.01 OTHER REVENUE -MRI	A	-2,450	MAGNETIC RESONANCE IMAGING (MRI)		58.00	0 33.01
33.02 ELIMINATE FINANCING COSTS	A	-36,309	ADMINISTRATIVE & GENERAL		5.00	0 33.02
33.03 NON OPERATING DONATIONS	B	-7,597	ADMINISTRATIVE & GENERAL		5.00	0 33.03
33.04 OTHER NON OPERATING REVENUE	B	-17,027	ADMINISTRATIVE & GENERAL		5.00	0 33.04
33.05 MALPRACTICE EXPENSE	A	-1,272,000	ADMINISTRATIVE & GENERAL		5.00	0 33.05
33.06 OTHER REVENUE - EMPLOYEE BENEFITS	B	-5,865	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.06
33.07 OTHER REVENUE - A&G	B	-815,305	ADMINISTRATIVE & GENERAL		5.00	0 33.07
33.08 OTHER REVENUE - PLANT OPERATIONS	B	-20,186	OPERATION OF PLANT		7.00	0 33.08
33.09 OTHER REVENUE - PHARMACY	B	-3,236	PHARMACY		15.00	0 33.09
33.10 OTHER REVENUE - MEDICAL RECORDS	B	-130,241	MEDICAL RECORDS & LIBRARY		16.00	0 33.10
33.11 OTHER REVENUE - ADULTS & PEDS	B	-36,542	ADULTS & PEDIATRICS		30.00	0 33.11
33.12 OTHER REVENUE - RADIOLOGY	B	-7,949	RADIOLOGY-DIAGNOSTIC		54.00	0 33.12
33.13 OTHER REVENUE - LAB	B	9,516	LABORATORY		60.00	0 33.13
33.14 OTHER REVENUE - P. T.	B	-88	PHYSICAL THERAPY		66.00	0 33.14
33.15 OTHER REVENUE - EKG	B	-19,267	ELECTROCARDIOLOGY		69.00	0 33.15
33.16 OTHER REVENUE - ER	B	-22,071	EMERGENCY		91.00	0 33.16
33.17 OTHER REVENUE - AMBULANCE	B	-72,674	AMBULANCE SERVICES		95.00	0 33.17
33.19 PENSION EXPENSE	B	-171	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.19
33.20 ALCOHOLIC BEVERAGES	B	-32	CARDIAC CATHETERIZATION		59.00	0 33.20
33.21 DISALLOWED INTEREST EXPENSE	B	-739,181	ADMINISTRATIVE & GENERAL		5.00	0 33.21
33.22 ENTERTAINMENT	B	-4,246	ADMINISTRATIVE & GENERAL		5.00	0 33.22
33.23 ACCELERATED DEPRECIATION	B	-523,539	ADMINISTRATIVE & GENERAL		5.00	0 33.23
33.24 VENDING MACHINE REVENUE	B	-27,203	DIETARY		10.00	0 33.24
33.25 ASBESTOS ABATEMENT	B	-81,952	ADMINISTRATIVE & GENERAL		5.00	0 33.25
33.26		0			0.00	0 33.26
33.27		0			0.00	0 33.27
33.28		0			0.00	0 33.28
33.29		0			0.00	0 33.29
33.30		0			0.00	0 33.30
33.31		0			0.00	0 33.31
33.32		0			0.00	0 33.32
33.33		0			0.00	0 33.33
33.34		0			0.00	0 33.34
33.35		0			0.00	0 33.35
34.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 34.00
35.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 35.00
36.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 36.00
37.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 37.00
38.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 38.00
39.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 39.00
40.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 40.00
41.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 41.00
42.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 42.00
43.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 43.00
44.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 44.00
45.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,957,742				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: 140002

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

Worksheet A-8-1

Date/Time Prepared:  
5/23/2016 1:51 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	BJC HEALTH SYSTEM	12,010,294	15,143,124 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CHRISTIAN HEALTH SERVICES	7,561	0 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	TELEPHONE FACILITIES CORP	60,091	61,803 3.00
4.00	60.00	LABORATORY	BARNES JEWISH LAB	44,711	32,507 4.00
4.01	60.00	LABORATORY	CHILDREN'S HOSPITAL LAB	3,389	6,459 4.01
4.02	50.00	OPERATING ROOM	MIDWEST SURGICAL TECHNOLOGIES	5,851	8,046 4.02
4.03	58.00	MAGNETIC RESONANCE IMAGING (	TWIN RIVERS MRI	103,365	135,000 4.03
5.00	0		0	12,235,262	15,386,939 5.00

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

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

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

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

6.00	G	BJC HEALTHCARE	100.00	0.00	6.00
7.00			0.00	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:	HOME OFFICE			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: 140002

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

Worksheet A-8-1

Date/Time Prepared:  
5/23/2016 1:51 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	-3,132,830	0		1.00
2.00	7,561	0		2.00
3.00	-1,712	0		3.00
4.00	12,204	0		4.00
4.01	-3,070	0		4.01
4.02	-2,195	0		4.02
4.03	-31,635	0		4.03
5.00	-3,151,677			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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: 140002

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

Worksheet A-8-2

Date/Time Prepared:  
5/23/2016 1:51 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	1,020,607	1,020,607	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	300,261	300,261	0	0	0	2.00
3.00	40.00	DR. A	54,000	54,000	0	0	0	3.00
4.00	44.00	DR. B	74	74	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	353,252	353,252	0	0	0	5.00
6.00	58.00	AGGREGATE-MAGNETIC RESONANCE IMAGING	262,500	262,500	0	0	0	6.00
7.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	241,992	241,992	0	0	0	7.00
8.00	76.00	AGGREGATE-ONCOLOGY	1,151,917	1,151,917	0	0	0	8.00
9.00	91.00	AGGREGATE-EMERGENCY	15,681	15,681	0	0	0	9.00
10.00	5.00	DR. D	688	0	688	211,500	9	10.00
11.00	5.00	DR. E	450	0	450	211,500	3	11.00
12.00	5.00	DR. F	1,800	0	1,800	246,400	4	12.00
200.00			3,403,222	3,400,284	2,938		16	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	40.00	DR. A	0	0	0	0	0	3.00
4.00	44.00	DR. B	0	0	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	5.00
6.00	58.00	AGGREGATE-MAGNETIC RESONANCE IMAGING	0	0	0	0	0	6.00
7.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	7.00
8.00	76.00	AGGREGATE-ONCOLOGY	0	0	0	0	0	8.00
9.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	9.00
10.00	5.00	DR. D	915	46	0	0	0	10.00
11.00	5.00	DR. E	305	15	0	0	0	11.00
12.00	5.00	DR. F	474	24	0	0	0	12.00
200.00			1,694	85	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	1,020,607		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	300,261		2.00
3.00	40.00	DR. A	0	0	0	54,000		3.00
4.00	44.00	DR. B	0	0	0	74		4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	353,252		5.00
6.00	58.00	AGGREGATE-MAGNETIC RESONANCE IMAGING	0	0	0	262,500		6.00
7.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	241,992		7.00
8.00	76.00	AGGREGATE-ONCOLOGY	0	0	0	1,151,917		8.00
9.00	91.00	AGGREGATE-EMERGENCY	0	0	0	15,681		9.00
10.00	5.00	DR. D	0	915	0	0		10.00
11.00	5.00	DR. E	0	305	145	145		11.00
12.00	5.00	DR. F	0	474	1,326	1,326		12.00
200.00			0	1,694	1,471	3,401,755		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140002

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4.03	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	4,702,922	4,702,922			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	5,277,651		5,277,651		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	984,921	25,616	1,116	1,011,653	4.00
4.03 00401	ADMITTING	1,283,720	56,532	10,615	24,313	1,375,180 4.03
5.00 00500	ADMINISTRATIVE & GENERAL	19,961,075	264,968	3,570,377	70,577	0 5.00
7.00 00700	OPERATION OF PLANT	2,963,923	1,829,617	19,944	19,719	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	361,034	11,454	198	0	0 8.00
9.00 00900	HOUSEKEEPING	1,422,407	27,084	313	23,941	0 9.00
10.00 01000	DIETARY	2,391,706	112,408	12,666	0	0 10.00
11.00 01100	CAFETERIA	-528,845	48,608	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,442,159	5,154	75,418	27,116	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	211,028	46,400	42,581	5,626	0 14.00
15.00 01500	PHARMACY	11,746,243	28,844	4,870	43,059	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	609,910	55,303	755	11,305	0 16.00
17.00 01700	SOCIAL SERVICE	1,217,132	5,456	2,405	22,835	0 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	11,380,511	571,389	66,935	204,533	103,663 30.00
31.00 03100	INTENSIVE CARE UNIT	2,454,518	57,146	60,902	45,415	24,194 31.00
40.00 04000	SUBPROVIDER - I/PF	1,460,010	76,514	161	28,523	10,942 40.00
44.00 04400	SKILLED NURSING FACILITY	1,710,449	40,256	7,887	31,795	10,411 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	4,954,267	215,600	217,352	51,273	82,464 50.00
51.00 05100	RECOVERY ROOM	730,017	35,206	398	13,332	15,925 51.00
53.00 05300	ANESTHESIOLOGY	299,933	2,541	68,092	1,642	27,402 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,128,202	113,699	415,172	54,427	100,399 54.00
56.00 05600	RADIOISOTOPE	457,065	10,423	917	4,902	13,063 56.00
57.00 05700	CT SCAN	493,161	5,925	0	7,267	115,602 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	309,158	20,857	1,331	4,905	16,790 58.00
59.00 05900	CARDIAC CATHETERIZATION	863,783	18,337	27,539	12,822	28,934 59.00
60.00 06000	LABORATORY	3,100,449	149,749	116,082	29,758	152,310 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	1,319,559	3,790	4,074	10,518	14,955 63.00
65.00 06500	RESPIRATORY THERAPY	1,116,299	16,057	21,159	18,035	22,733 65.00
66.00 06600	PHYSICAL THERAPY	1,406,985	56,490	23,277	25,767	27,636 66.00
67.00 06700	OCCUPATIONAL THERAPY	281,094	15,213	4,090	5,845	6,318 67.00
68.00 06800	SPEECH PATHOLOGY	197,641	5,206	0	4,027	2,807 68.00
69.00 06900	ELECTROCARDIOLOGY	1,236,152	52,606	77,847	21,638	62,443 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,441,327	0	0	0	36,116 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	7,693,715	0	0	0	80,124 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	176,219 73.00
74.00 07400	RENAL DIALYSIS	389,645	2,916	0	0	4,082 74.00
76.00 03020	ONCOLOGY	921,699	18,504	3,264	17,112	9,225 76.00
76.01 03340	GASTROINTESTINAL SERVICES	1,056,019	35,633	127,168	17,557	33,288 76.01
76.02 03550	OP PSYCH	454,749	40,423	22,895	8,798	7,287 76.02
76.98 07698	HYPERBARI C OXYGEN THERAPY	259,738	0	0	56	5,672 76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	3,956,976	173,126	61,851	72,398	135,006 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	2,853,500	10,163	203,234	49,253	49,170 95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	110,973,607	4,265,213	5,272,885	990,089	1,375,180 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	94,943	10,788	1,884	701	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
192.01 19201	TWIN RIVERS MRI	0	29,198	0	0	0 192.01
193.00 19300	NONPAID WORKERS	15,145	16,619	307	258	0 193.00
193.01 19301	PHYSICIAN/PUBLIC RELATIONS	988,760	10,840	1,504	4,986	0 193.01
193.02 19302	MEDICAL OFFICE BUILDING	685,664	0	0	4,731	0 193.02
193.03 19303	HOME CARE PHARMACY	3,298,774	5,009	1,071	9,069	0 193.03
193.04 19304	MANAGEMENT SERVICES	0	0	0	0	0 193.04
193.05 19305	EUNICE SMITH NURSING HOME	0	0	0	0	0 193.05
193.06 19306	VACANT SPACE	0	363,360	0	0	0 193.06
193.07 19307	POB 2	505,102	0	0	1,819	0 193.07
193.08 19308	NON REIMBURSABLE MEALS	0	0	0	0	0 193.08
193.09 19309	COFFEE BAR	46,011	1,895	0	0	0 193.09
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	116,608,006	4,702,922	5,277,651	1,011,653	1,375,180 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140002

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A.03	5.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.03	00401	ADMINISTRATIVE					4.03
5.00	00500	ADMINISTRATIVE & GENERAL	23,866,997	23,866,997			5.00
7.00	00700	OPERATION OF PLANT	4,833,203	1,237,421	6,070,624		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	372,686	95,417	27,525	495,628	8.00
9.00	00900	HOUSEKEEPING	1,473,745	377,316	65,085	0	1,916,146
10.00	01000	DIETARY	2,516,780	644,359	270,124	0	86,583
11.00	01100	CAFETERIA	-480,237	0	116,808	0	37,441
13.00	01300	NURSING ADMINISTRATION	1,549,847	396,800	12,386	0	3,970
14.00	01400	CENTRAL SERVICES & SUPPLY	305,635	78,250	111,503	3,178	35,740
15.00	01500	PHARMACY	11,823,016	3,026,988	69,314	269	22,217
16.00	01600	MEDICAL RECORDS & LIBRARY	677,273	173,399	132,898	0	42,598
17.00	01700	SOCIAL SERVICE	1,247,828	319,475	13,112	0	4,203
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	12,327,031	3,156,057	1,373,089	189,754	440,121
31.00	03100	INTENSIVE CARE UNIT	2,642,175	676,463	137,327	25,573	44,018
40.00	04000	SUBPROVIDER - IPF	1,576,150	403,534	183,870	8,576	58,936
44.00	04400	SKILLED NURSING FACILITY	1,800,798	461,049	96,739	21,952	31,008
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	5,520,956	1,413,503	518,103	62,220	166,069
51.00	05100	RECOVERY ROOM	794,878	203,509	84,603	3,355	27,118
53.00	05300	ANESTHESIOLOGY	399,610	102,310	6,106	0	1,957
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,811,899	975,941	273,227	31,372	87,578
56.00	05600	RADIOISOTOPE	486,370	124,523	25,048	1,240	8,029
57.00	05700	CT SCAN	621,955	159,236	14,238	7,847	4,564
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	353,041	90,387	50,121	303	16,065
59.00	05900	CARDIAC CATHETERIZATION	951,415	243,586	44,066	6,674	14,124
60.00	06000	LABORATORY	3,548,348	908,466	359,857	0	115,346
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,352,896	346,375	9,108	0	2,920
65.00	06500	RESPIRATORY THERAPY	1,194,283	305,766	38,586	0	12,368
66.00	06600	PHYSICAL THERAPY	1,540,155	394,318	135,750	4,185	43,512
67.00	06700	OCCUPATIONAL THERAPY	312,560	80,023	36,559	0	11,718
68.00	06800	SPEECH PATHOLOGY	209,681	53,684	12,512	0	4,010
69.00	06900	ELECTROCARDIOLOGY	1,450,686	371,412	126,417	80	40,521
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,477,443	634,287	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,773,839	1,990,297	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	176,219	45,116	0	0	0
74.00	07400	RENAL DIALYSIS	396,643	101,551	7,006	0	2,246
76.00	03020	ONCOLOGY	969,804	248,294	44,466	0	14,253
76.01	03340	GASTRO INTESTINAL SERVICES	1,269,665	325,066	85,629	31,287	27,447
76.02	03550	OP PSYCH	534,152	136,756	97,140	10	31,136
76.98	07698	HYPERBARIC OXYGEN THERAPY	265,466	67,966	0	5,128	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	4,399,357	1,126,345	416,034	66,547	133,352
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0				
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	3,165,320	810,401	24,423	25,646	7,828
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	110,509,568	22,305,646	5,018,779	495,196	1,578,996
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	108,316	27,732	25,924	0	8,309
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	TWIN RIVERS MRI	29,198	7,475	70,165	432	22,490
193.00	19300	NONPAID WORKERS	32,329	8,277	39,937	0	12,801
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	1,006,090	257,584	26,049	0	8,350
193.02	19302	MEDICAL OFFICE BUILDING	690,395	176,758	0	0	0
193.03	19303	HOME CARE PHARMACY	3,313,923	848,447	12,036	0	3,858
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0
193.06	19306	VACANT SPACE	363,360	93,029	873,180	0	279,882
193.07	19307	POB 2	506,921	129,784	0	0	0
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0
193.09	19309	COFFEE BAR	47,906	12,265	4,554	0	1,460
200.00		Cross Foot Adjustments	0				
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	116,608,006	23,866,997	6,070,624	495,628	1,916,146

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140002

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
4.03	00401						4.03
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	3,517,846					10.00
11.00	01100	1,593,581	1,267,593				11.00
13.00	01300	0	29,237	1,992,240			13.00
14.00	01400	0	13,016	0	547,322		14.00
15.00	01500	0	43,187	0	0	14,984,991	15.00
16.00	01600	0	24,694	0	0	0	16.00
17.00	01700	0	28,664	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	698,495	294,415	1,204,791	0	0	30.00
31.00	03100	92,436	58,708	240,283	0	0	31.00
40.00	04000	103,743	38,877	159,137	0	0	40.00
44.00	04400	161,916	48,050	196,691	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	70,153	0	0	0	50.00
51.00	05100	0	13,440	0	0	0	51.00
53.00	05300	0	2,951	0	0	0	53.00
54.00	05400	0	77,754	0	0	0	54.00
56.00	05600	0	6,094	0	0	0	56.00
57.00	05700	0	10,446	0	0	0	57.00
58.00	05800	0	7,283	0	0	0	58.00
59.00	05900	0	15,946	0	0	0	59.00
60.00	06000	0	56,309	0	0	0	60.00
63.00	06300	0	19,131	0	0	0	63.00
65.00	06500	0	27,050	0	0	0	65.00
66.00	06600	0	34,546	0	0	0	66.00
67.00	06700	0	8,026	0	0	0	67.00
68.00	06800	0	3,716	0	0	0	68.00
69.00	06900	0	29,938	0	0	0	69.00
71.00	07100	0	0	0	148,215	0	71.00
72.00	07200	0	0	0	399,107	0	72.00
73.00	07300	0	0	0	0	14,984,991	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03020	0	28,006	113,238	0	0	76.00
76.01	03340	0	20,107	78,100	0	0	76.01
76.02	03550	0	15,415	0	0	0	76.02
76.98	07698	0	0	0	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	99,581	0	0	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	103,828	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		2,650,171	1,228,568	1,992,240	547,322	14,984,991	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	1,975	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
193.00	19300	0	786	0	0	0	193.00
193.01	19301	0	6,157	0	0	0	193.01
193.02	19302	0	11,529	0	0	0	193.02
193.03	19303	0	12,973	0	0	0	193.03
193.04	19304	0	0	0	0	0	193.04
193.05	19305	715,979	0	0	0	0	193.05
193.06	19306	0	0	0	0	0	193.06
193.07	19307	0	5,605	0	0	0	193.07
193.08	19308	151,696	0	0	0	0	193.08
193.09	19309	0	0	0	0	0	193.09
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		3,517,846	1,267,593	1,992,240	547,322	14,984,991	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140002

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,050,862					16.00
17.00	01700	SOCIAL SERVICE	0	1,613,282				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	79,228	1,091,861	20,854,842	0	20,854,842	30.00
31.00	03100	INTENSIVE CARE UNIT	18,491	134,598	4,070,072	0	4,070,072	31.00
40.00	04000	SUBPROVIDER - IPF	8,363	151,058	2,692,244	0	2,692,244	40.00
44.00	04400	SKILLED NURSING FACILITY	7,957	235,765	3,061,925	0	3,061,925	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	63,026	0	7,814,030	0	7,814,030	50.00
51.00	05100	RECOVERY ROOM	12,171	0	1,139,074	0	1,139,074	51.00
53.00	05300	ANESTHESIOLOGY	20,943	0	533,877	0	533,877	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,733	0	5,334,504	0	5,334,504	54.00
56.00	05600	RADIOISOTOPE	9,984	0	661,288	0	661,288	56.00
57.00	05700	CT SCAN	88,353	0	906,639	0	906,639	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	12,832	0	530,032	0	530,032	58.00
59.00	05900	CARDIAC CATHETERIZATION	22,114	0	1,297,925	0	1,297,925	59.00
60.00	06000	LABORATORY	116,408	0	5,104,734	0	5,104,734	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	11,430	0	1,741,860	0	1,741,860	63.00
65.00	06500	RESPIRATORY THERAPY	17,374	0	1,595,427	0	1,595,427	65.00
66.00	06600	PHYSICAL THERAPY	21,122	0	2,173,588	0	2,173,588	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,829	0	453,715	0	453,715	67.00
68.00	06800	SPEECH PATHOLOGY	2,146	0	285,749	0	285,749	68.00
69.00	06900	ELECTROCARDIOLOGY	47,724	0	2,066,778	0	2,066,778	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,603	0	3,287,548	0	3,287,548	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	61,237	0	10,224,480	0	10,224,480	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	134,514	0	15,340,840	0	15,340,840	73.00
74.00	07400	RENAL DIALYSIS	3,120	0	510,566	0	510,566	74.00
76.00	03020	ONCOLOGY	7,051	0	1,425,112	0	1,425,112	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	25,442	0	1,862,743	0	1,862,743	76.01
76.02	03550	OP PSYCH	5,569	0	820,178	0	820,178	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,335	0	342,895	0	342,895	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	103,183	0	6,344,399	0	6,344,399	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	37,580	0	4,175,026	0	4,175,026	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,050,862	1,613,282	106,652,090	0	106,652,090	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	172,256	0	172,256	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	129,760	0	129,760	192.01
193.00	19300	NONPAID WORKERS	0	0	94,130	0	94,130	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	0	1,304,230	0	1,304,230	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	0	878,682	0	878,682	193.02
193.03	19303	HOME CARE PHARMACY	0	0	4,191,237	0	4,191,237	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	715,979	0	715,979	193.05
193.06	19306	VACANT SPACE	0	0	1,609,451	0	1,609,451	193.06
193.07	19307	POB 2	0	0	642,310	0	642,310	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	151,696	0	151,696	193.08
193.09	19309	COFFEE BAR	0	0	66,185	0	66,185	193.09
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,050,862	1,613,282	116,608,006	0	116,608,006	202.00

COST ALLOCATION STATISTICS

Provider CCN: 140002

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

Worksheet Non-CMS W  
Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	5	GROSS SALARIES	4.00
4.03	ADMINISTRATIVE	7	GROSS REVENUE	4.03
5.00	ADMINISTRATIVE & GENERAL	-21	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	12	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	14	MEALS SERVED	10.00
11.00	CAFETERIA	15	FTE'S	11.00
13.00	NURSING ADMINISTRATION	16	HOURS OF SERVICE	13.00
14.00	CENTRAL SERVICES & SUPPLY	17	COSTED REQUISITIONS	14.00
15.00	PHARMACY	18	COSTED REQUISITIONS	15.00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16.00
17.00	SOCIAL SERVICE	20	PATIENT DAYS	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140002

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,245	25,616	1,116	31,977	4.00
4.03 00401	ADMINITTING	6,343	56,532	10,615	73,490	4.03
5.00 00500	ADMINISTRATIVE & GENERAL	725,131	264,968	3,570,377	4,560,476	5.00
7.00 00700	OPERATION OF PLANT	3,583	1,829,617	19,944	1,853,144	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	11,454	198	11,652	8.00
9.00 00900	HOUSEKEEPING	429	27,084	313	27,826	9.00
10.00 01000	DIETARY	27,613	112,408	12,666	152,687	10.00
11.00 01100	CAFETERIA	0	48,608	0	48,608	11.00
13.00 01300	NURSING ADMINISTRATION	0	5,154	75,418	80,572	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	370	46,400	42,581	89,351	14.00
15.00 01500	PHARMACY	133,811	28,844	4,870	167,525	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	11,008	55,303	755	67,066	16.00
17.00 01700	SOCIAL SERVICE	2,235	5,456	2,405	10,096	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	437,020	571,389	66,935	1,075,344	30.00
31.00 03100	INTENSIVE CARE UNIT	3,260	57,146	60,902	121,308	31.00
40.00 04000	SUBPROVIDER - IPF	2,426	76,514	161	79,101	40.00
44.00 04400	SKILLED NURSING FACILITY	2,839	40,256	7,887	50,982	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	9,680	215,600	217,352	442,632	50.00
51.00 05100	RECOVERY ROOM	377	35,206	398	35,981	51.00
53.00 05300	ANESTHESIOLOGY	0	2,541	68,092	70,633	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	6,037	113,699	415,172	534,908	54.00
56.00 05600	RADIOISOTOPE	0	10,423	917	11,340	56.00
57.00 05700	CT SCAN	0	5,925	0	5,925	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,269	20,857	1,331	23,457	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	18,337	27,539	45,876	59.00
60.00 06000	LABORATORY	7,127	149,749	116,082	272,958	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	3,790	4,074	7,864	63.00
65.00 06500	RESPIRATORY THERAPY	9,937	16,057	21,159	47,153	65.00
66.00 06600	PHYSICAL THERAPY	3,138	56,490	23,277	82,905	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	15,213	4,090	19,303	67.00
68.00 06800	SPEECH PATHOLOGY	0	5,206	0	5,206	68.00
69.00 06900	ELECTROCARDIOLOGY	877	52,606	77,847	131,330	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	2,916	0	2,916	74.00
76.00 03020	ONCOLOGY	7,944	18,504	3,264	29,712	76.00
76.01 03340	GASTRO INTESTINAL SERVICES	824	35,633	127,168	163,625	76.01
76.02 03550	OP PSYCH	2,748	40,423	22,895	66,066	76.02
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	6,450	173,126	61,851	241,427	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	8,488	10,163	203,234	221,885	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,426,209	4,265,213	5,272,885	10,964,307	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,788	1,884	12,672	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	TWIN RIVERS MRI	0	29,198	0	29,198	192.01
193.00 19300	NONPAID WORKERS	0	16,619	307	16,926	193.00
193.01 19301	PHYSICIAN/PUBLIC RELATIONS	0	10,840	1,504	12,344	193.01
193.02 19302	MEDICAL OFFICE BUILDING	0	0	0	0	193.02
193.03 19303	HOME CARE PHARMACY	0	5,009	1,071	6,080	193.03
193.04 19304	MANAGEMENT SERVICES	0	0	0	0	193.04
193.05 19305	EUNICE SMITH NURSING HOME	0	0	0	0	193.05
193.06 19306	VACANT SPACE	0	363,360	0	363,360	193.06
193.07 19307	POB 2	0	0	0	0	193.07
193.08 19308	NON REIMBURSABLE MEALS	0	0	0	0	193.08
193.09 19309	COFFEE BAR	0	1,895	0	1,895	193.09
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,426,209	4,702,922	5,277,651	11,406,782	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/23/2016 1:51 pm		
Cost Center Description			ADMINISTRATIVE	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			4.03	5.00	7.00	8.00	9.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.03	00401	ADMINISTRATIVE	74,258				4.03
5.00	00500	ADMINISTRATIVE & GENERAL	0	4,562,707			5.00
7.00	00700	OPERATION OF PLANT	0	236,561	2,090,328		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,241	9,478	39,371	8.00
9.00	00900	HOUSEKEEPING	0	72,132	22,411	0	123,126
10.00	01000	DIETARY	0	123,184	93,013	0	5,564
11.00	01100	CAFETERIA	0	0	40,221	0	2,406
13.00	01300	NURSING ADMINISTRATION	0	75,857	4,265	0	255
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,959	38,394	252	2,297
15.00	01500	PHARMACY	0	578,678	23,867	21	1,428
16.00	01600	MEDICAL RECORDS & LIBRARY	0	33,149	45,761	0	2,737
17.00	01700	SOCIAL SERVICE	0	61,075	4,515	0	270
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	5,584	603,340	472,803	15,078	28,277
31.00	03100	INTENSIVE CARE UNIT	1,303	129,321	47,286	2,031	2,828
40.00	04000	SUBPROVIDER - I/PF	589	77,145	63,313	681	3,787
44.00	04400	SKILLED NURSING FACILITY	561	88,140	33,311	1,744	1,992
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	4,442	270,223	178,401	4,943	10,671
51.00	05100	RECOVERY ROOM	858	38,905	29,132	266	1,743
53.00	05300	ANESTHESIOLOGY	1,476	19,559	2,102	0	126
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,408	186,573	94,082	2,492	5,628
56.00	05600	RADIOISOTOPE	704	23,805	8,625	98	516
57.00	05700	CT SCAN	6,227	30,442	4,903	623	293
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	904	17,280	17,258	24	1,032
59.00	05900	CARDIAC CATHETERIZATION	1,559	46,567	15,173	530	908
60.00	06000	LABORATORY	8,205	173,674	123,911	0	7,412
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	806	66,217	3,136	0	188
65.00	06500	RESPIRATORY THERAPY	1,225	58,454	13,286	0	795
66.00	06600	PHYSICAL THERAPY	1,489	75,383	46,744	332	2,796
67.00	06700	OCCUPATIONAL THERAPY	340	15,298	12,588	0	753
68.00	06800	SPEECH PATHOLOGY	151	10,263	4,308	0	258
69.00	06900	ELECTROCARDIOLOGY	3,364	71,004	43,530	6	2,604
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,946	121,258	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,316	380,491	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	9,670	8,625	0	0	0
74.00	07400	RENAL DIALYSIS	220	19,414	2,413	0	144
76.00	03020	ONCOLOGY	497	47,467	15,311	0	916
76.01	03340	GASTRO INTESTINAL SERVICES	1,793	62,144	29,485	2,485	1,764
76.02	03550	OP PSYCH	393	26,144	33,449	1	2,001
76.98	07698	HYPERBARIC OXYGEN THERAPY	306	12,993	0	407	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	7,273	215,327	143,255	5,286	8,569
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	2,649	154,927	8,410	2,037	503
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,258	4,264,219	1,728,140	39,337	101,461
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,302	8,927	0	534
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	TWIN RIVERS MRI	0	1,429	24,160	34	1,445
193.00	19300	NONPAID WORKERS	0	1,582	13,752	0	823
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	49,243	8,970	0	537
193.02	19302	MEDICAL OFFICE BUILDING	0	33,791	0	0	0
193.03	19303	HOME CARE PHARMACY	0	162,200	4,144	0	248
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0
193.06	19306	VACANT SPACE	0	17,785	300,667	0	17,984
193.07	19307	POB 2	0	24,811	0	0	0
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0
193.09	19309	COFFEE BAR	0	2,345	1,568	0	94
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	74,258	4,562,707	2,090,328	39,371	123,126

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140002

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
4.03	00401						4.03
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	374,448					10.00
11.00	01100	169,624	184,066				11.00
13.00	01300	0	4,246	166,052			13.00
14.00	01400	0	1,890	0	147,321		14.00
15.00	01500	0	6,271	0	0	779,151	15.00
16.00	01600	0	3,586	0	0	0	16.00
17.00	01700	0	4,162	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	74,350	42,750	100,419	0	0	30.00
31.00	03100	9,839	8,525	20,027	0	0	31.00
40.00	04000	11,043	5,645	13,264	0	0	40.00
44.00	04400	17,235	6,977	16,394	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	10,187	0	0	0	50.00
51.00	05100	0	1,952	0	0	0	51.00
53.00	05300	0	429	0	0	0	53.00
54.00	05400	0	11,291	0	0	0	54.00
56.00	05600	0	885	0	0	0	56.00
57.00	05700	0	1,517	0	0	0	57.00
58.00	05800	0	1,058	0	0	0	58.00
59.00	05900	0	2,315	0	0	0	59.00
60.00	06000	0	8,177	0	0	0	60.00
63.00	06300	0	2,778	0	0	0	63.00
65.00	06500	0	3,928	0	0	0	65.00
66.00	06600	0	5,016	0	0	0	66.00
67.00	06700	0	1,165	0	0	0	67.00
68.00	06800	0	540	0	0	0	68.00
69.00	06900	0	4,347	0	0	0	69.00
71.00	07100	0	0	0	39,895	0	71.00
72.00	07200	0	0	0	107,426	0	72.00
73.00	07300	0	0	0	0	779,151	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03020	0	4,067	9,438	0	0	76.00
76.01	03340	0	2,920	6,510	0	0	76.01
76.02	03550	0	2,238	0	0	0	76.02
76.98	07698	0	0	0	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	14,460	0	0	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	15,077	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		282,091	178,399	166,052	147,321	779,151	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	287	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
193.00	19300	0	114	0	0	0	193.00
193.01	19301	0	894	0	0	0	193.01
193.02	19302	0	1,674	0	0	0	193.02
193.03	19303	0	1,884	0	0	0	193.03
193.04	19304	0	0	0	0	0	193.04
193.05	19305	76,210	0	0	0	0	193.05
193.06	19306	0	0	0	0	0	193.06
193.07	19307	0	814	0	0	0	193.07
193.08	19308	16,147	0	0	0	0	193.08
193.09	19309	0	0	0	0	0	193.09
200.00		0	0	0	0	0	200.00
201.00		0	76,793	0	0	0	201.00
202.00		374,448	260,859	166,052	147,321	779,151	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140002

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	152,656					16.00
17.00	01700	SOCIAL SERVICE	0	80,840				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,507	54,712	2,490,629	0	2,490,629	30.00
31.00	03100	INTENSIVE CARE UNIT	2,686	6,745	353,334	0	353,334	31.00
40.00	04000	SUBPROVIDER - IPF	1,215	7,569	264,254	0	264,254	40.00
44.00	04400	SKILLED NURSING FACILITY	1,156	11,814	231,311	0	231,311	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,154	0	932,274	0	932,274	50.00
51.00	05100	RECOVERY ROOM	1,768	0	111,026	0	111,026	51.00
53.00	05300	ANESTHESIOLOGY	3,042	0	97,419	0	97,419	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,144	0	853,246	0	853,246	54.00
56.00	05600	RADIOISOTOPE	1,450	0	47,578	0	47,578	56.00
57.00	05700	CT SCAN	12,832	0	62,992	0	62,992	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,864	0	63,032	0	63,032	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,212	0	116,545	0	116,545	59.00
60.00	06000	LABORATORY	16,907	0	612,185	0	612,185	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,660	0	82,981	0	82,981	63.00
65.00	06500	RESPIRATORY THERAPY	2,523	0	127,934	0	127,934	65.00
66.00	06600	PHYSICAL THERAPY	3,068	0	218,547	0	218,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	701	0	50,333	0	50,333	67.00
68.00	06800	SPEECH PATHOLOGY	312	0	21,165	0	21,165	68.00
69.00	06900	ELECTROCARDIOLOGY	6,931	0	263,800	0	263,800	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,009	0	167,108	0	167,108	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,894	0	501,127	0	501,127	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,566	0	817,012	0	817,012	73.00
74.00	07400	RENAL DIALYSIS	453	0	25,560	0	25,560	74.00
76.00	03020	ONCOLOGY	1,024	0	108,973	0	108,973	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	3,695	0	274,976	0	274,976	76.01
76.02	03550	OP PSYCH	809	0	131,379	0	131,379	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	630	0	14,338	0	14,338	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	14,986	0	652,871	0	652,871	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	5,458	0	412,503	0	412,503	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	152,656	80,840	10,106,432	0	10,106,432	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	27,744	0	27,744	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	56,266	0	56,266	192.01
193.00	19300	NONPAID WORKERS	0	0	33,205	0	33,205	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	0	72,146	0	72,146	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	0	35,615	0	35,615	193.02
193.03	19303	HOME CARE PHARMACY	0	0	174,843	0	174,843	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	76,210	0	76,210	193.05
193.06	19306	VACANT SPACE	0	0	699,796	0	699,796	193.06
193.07	19307	POB 2	0	0	25,683	0	25,683	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	16,147	0	16,147	193.08
193.09	19309	COFFEE BAR	0	0	5,902	0	5,902	193.09
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	76,793	0	76,793	201.00
202.00		TOTAL (sum lines 118-201)	152,656	80,840	11,406,782	0	11,406,782	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140002

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

Worksheet B-1

Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUE)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	451,642				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		5,224,987			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,460	1,105	39,869,538		4.00
4.03 00401	ADMITTING	5,429	10,509	958,168	448,902,654	4.03
5.00 00500	ADMINISTRATIVE & GENERAL	25,446	3,534,751	2,781,456	0	-23,866,997
7.00 00700	OPERATION OF PLANT	175,706	19,745	777,152	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	1,100	196	0	0	0
9.00 00900	HOUSEKEEPING	2,601	310	943,530	0	0
10.00 01000	DIETARY	10,795	12,540	0	0	0
11.00 01100	CAFETERIA	4,668	0	0	0	480,237
13.00 01300	NURSING ADMINISTRATION	495	74,665	1,068,648	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	4,456	42,156	221,723	0	0
15.00 01500	PHARMACY	2,770	4,821	1,696,961	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	5,311	747	445,552	0	0
17.00 01700	SOCIAL SERVICE	524	2,381	899,933	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	54,873	66,267	8,060,496	33,843,650	0
31.00 03100	INTENSIVE CARE UNIT	5,488	60,294	1,789,830	7,898,704	0
40.00 04000	SUBPROVIDER - I/PF	7,348	159	1,124,115	3,572,455	0
44.00 04400	SKILLED NURSING FACILITY	3,866	7,808	1,253,040	3,398,853	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	20,705	215,183	2,020,687	26,922,780	0
51.00 05100	RECOVERY ROOM	3,381	394	525,421	5,199,180	0
53.00 05300	ANESTHESIOLOGY	244	67,413	64,694	8,946,000	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	10,919	411,029	2,144,989	32,777,915	0
56.00 05600	RADIOISOTOPE	1,001	908	193,180	4,264,691	0
57.00 05700	CT SCAN	569	0	286,384	37,741,359	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	2,003	1,318	193,322	5,481,548	0
59.00 05900	CARDIAC CATHETERIZATION	1,761	27,264	505,329	9,446,272	0
60.00 06000	LABORATORY	14,381	114,924	1,172,787	49,725,729	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	364	4,033	414,524	4,882,327	0
65.00 06500	RESPIRATORY THERAPY	1,542	20,948	710,776	7,421,659	0
66.00 06600	PHYSICAL THERAPY	5,425	23,045	1,015,482	9,022,630	0
67.00 06700	OCCUPATIONAL THERAPY	1,461	4,049	230,369	2,062,627	0
68.00 06800	SPEECH PATHOLOGY	500	0	158,716	916,555	0
69.00 06900	ELECTROCARDIOLOGY	5,052	77,070	852,781	20,386,178	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,790,913	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	26,158,632	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	57,469,876	0
74.00 07400	RENAL DIALYSIS	280	0	0	1,332,578	0
76.00 03020	ONCOLOGY	1,777	3,231	674,380	3,011,782	0
76.01 03340	GASTROINTESTINAL SERVICES	3,422	125,899	691,926	10,867,792	0
76.02 03550	OP PSYCH	3,882	22,667	346,728	2,378,880	0
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	2,218	1,851,655	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	16,626	61,234	2,853,239	44,076,509	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	976	201,206	1,941,094	16,052,925	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	409,607	5,220,269	39,019,630	448,902,654	-23,386,760
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,036	1,865	27,623	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01 19201	TWIN RIVERS MRI	2,804	0	0	0	0
193.00 19300	NONPAID WORKERS	1,596	304	10,178	0	0
193.01 19301	PHYSICIAN/PUBLIC RELATIONS	1,041	1,489	196,513	0	0
193.02 19302	MEDICAL OFFICE BUILDING	0	0	186,468	0	0
193.03 19303	HOME CARE PHARMACY	481	1,060	357,420	0	0
193.04 19304	MANAGEMENT SERVICES	0	0	0	0	0
193.05 19305	EUNICE SMITH NURSING HOME	0	0	0	0	0
193.06 19306	VACANT SPACE	34,895	0	0	0	0
193.07 19307	POB 2	0	0	71,706	0	0
193.08 19308	NON REIMBURSABLE MEALS	0	0	0	0	0
193.09 19309	COFFEE BAR	182	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140002

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

Worksheet B-1

Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUE)	Reconciliation	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
202.00	Cost to be allocated (per Wkst. B, Part I)	4,702,922	5,277,651	1,011,653	1,375,180		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10.412942	1.010079	0.025374	0.003063		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			31,977	74,258		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000802	0.000165		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140002

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

Worksheet B-1

Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.03	00401	ADMINITTING					4.03
5.00	00500	ADMINISTRATIVE & GENERAL	93,221,246				5.00
7.00	00700	OPERATION OF PLANT	4,833,203	242,601			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	372,686	1,100	562,457		8.00
9.00	00900	HOUSEKEEPING	1,473,745	2,601	0	238,900	9.00
10.00	01000	DIETARY	2,516,780	10,795	0	10,795	349,707
11.00	01100	CAFETERIA	0	4,668	0	4,668	158,417
13.00	01300	NURSING ADMINISTRATION	1,549,847	495	0	495	0
14.00	01400	CENTRAL SERVICES & SUPPLY	305,635	4,456	3,607	4,456	0
15.00	01500	PHARMACY	11,823,016	2,770	305	2,770	0
16.00	01600	MEDICAL RECORDS & LIBRARY	677,273	5,311	0	5,311	0
17.00	01700	SOCIAL SERVICE	1,247,828	524	0	524	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	12,327,031	54,873	215,340	54,873	69,437
31.00	03100	INTENSIVE CARE UNIT	2,642,175	5,488	29,021	5,488	9,189
40.00	04000	SUBPROVIDER - IPF	1,576,150	7,348	9,732	7,348	10,313
44.00	04400	SKILLED NURSING FACILITY	1,800,798	3,866	24,912	3,866	16,096
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	5,520,956	20,705	70,610	20,705	0
51.00	05100	RECOVERY ROOM	794,878	3,381	3,807	3,381	0
53.00	05300	ANESTHESIOLOGY	399,610	244	0	244	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,811,899	10,919	35,602	10,919	0
56.00	05600	RADIOISOTOPE	486,370	1,001	1,407	1,001	0
57.00	05700	CT SCAN	621,955	569	8,905	569	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	353,041	2,003	344	2,003	0
59.00	05900	CARDIAC CATHETERIZATION	951,415	1,761	7,574	1,761	0
60.00	06000	LABORATORY	3,548,348	14,381	0	14,381	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,352,896	364	0	364	0
65.00	06500	RESPIRATORY THERAPY	1,194,283	1,542	0	1,542	0
66.00	06600	PHYSICAL THERAPY	1,540,155	5,425	4,749	5,425	0
67.00	06700	OCCUPATIONAL THERAPY	312,560	1,461	0	1,461	0
68.00	06800	SPEECH PATHOLOGY	209,681	500	0	500	0
69.00	06900	ELECTROCARDIOLOGY	1,450,686	5,052	91	5,052	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,477,443	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,773,839	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	176,219	0	0	0	0
74.00	07400	RENAL DIALYSIS	396,643	280	0	280	0
76.00	03020	ONCOLOGY	969,804	1,777	0	1,777	0
76.01	03340	GASTROINTESTINAL SERVICES	1,269,665	3,422	35,506	3,422	0
76.02	03550	OP PSYCH	534,152	3,882	11	3,882	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	265,466	0	5,820	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	4,399,357	16,626	75,520	16,626	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	3,165,320	976	29,104	976	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	87,122,808	200,566	561,967	196,865	263,452
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	108,316	1,036	0	1,036	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	TWIN RIVERS MRI	29,198	2,804	490	2,804	0
193.00	19300	NONPAID WORKERS	32,329	1,596	0	1,596	0
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	1,006,090	1,041	0	1,041	0
193.02	19302	MEDICAL OFFICE BUILDING	690,395	0	0	0	0
193.03	19303	HOME CARE PHARMACY	3,313,923	481	0	481	0
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	71,175
193.06	19306	VACANT SPACE	363,360	34,895	0	34,895	0
193.07	19307	POB 2	506,921	0	0	0	0
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	15,080
193.09	19309	COFFEE BAR	47,906	182	0	182	0
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)	23,866,997	6,070,624	495,628	1,916,146	3,517,846
203.00		Unit cost multiplier (Wkst. B, Part I)	0.256025	25.023079	0.881184	8.020703	10.059410

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 140002		Period: From 01/01/2015 To 12/31/2015		Worksheet B-1 Date/Time Prepared: 5/23/2016 1:51 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	4,562,707	2,090,328	39,371	123,126	374,448	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.048945	8.616321	0.069998	0.515387	1.070748	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140002

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

Worksheet B-1

Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description		CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
4.03	00401						4.03
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	59,700					11.00
13.00	01300	1,377	476,762				13.00
14.00	01400	613	0	10,000			14.00
15.00	01500	2,034	0	0	100		15.00
16.00	01600	1,163	0	0	0	448,902,654	16.00
17.00	01700	1,350	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	13,866	288,318	0	0	33,843,650	30.00
31.00	03100	2,765	57,502	0	0	7,898,704	31.00
40.00	04000	1,831	38,083	0	0	3,572,455	40.00
44.00	04400	2,263	47,070	0	0	3,398,853	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	3,304	0	0	0	26,922,780	50.00
51.00	05100	633	0	0	0	5,199,180	51.00
53.00	05300	139	0	0	0	8,946,000	53.00
54.00	05400	3,662	0	0	0	32,777,915	54.00
56.00	05600	287	0	0	0	4,264,691	56.00
57.00	05700	492	0	0	0	37,741,359	57.00
58.00	05800	343	0	0	0	5,481,548	58.00
59.00	05900	751	0	0	0	9,446,272	59.00
60.00	06000	2,652	0	0	0	49,725,729	60.00
63.00	06300	901	0	0	0	4,882,327	63.00
65.00	06500	1,274	0	0	0	7,421,659	65.00
66.00	06600	1,627	0	0	0	9,022,630	66.00
67.00	06700	378	0	0	0	2,062,627	67.00
68.00	06800	175	0	0	0	916,555	68.00
69.00	06900	1,410	0	0	0	20,386,178	69.00
71.00	07100	0	0	2,708	0	11,790,913	71.00
72.00	07200	0	0	7,292	0	26,158,632	72.00
73.00	07300	0	0	0	100	57,469,876	73.00
74.00	07400	0	0	0	0	1,332,578	74.00
76.00	03020	1,319	27,099	0	0	3,011,782	76.00
76.01	03340	947	18,690	0	0	10,867,792	76.01
76.02	03550	726	0	0	0	2,378,880	76.02
76.98	07698	0	0	0	0	1,851,655	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	4,690	0	0	0	44,076,509	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	4,890	0	0	0	16,052,925	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		57,862	476,762	10,000	100	448,902,654	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	93	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
193.00	19300	37	0	0	0	0	193.00
193.01	19301	290	0	0	0	0	193.01
193.02	19302	543	0	0	0	0	193.02
193.03	19303	611	0	0	0	0	193.03
193.04	19304	0	0	0	0	0	193.04
193.05	19305	0	0	0	0	0	193.05
193.06	19306	0	0	0	0	0	193.06
193.07	19307	264	0	0	0	0	193.07
193.08	19308	0	0	0	0	0	193.08
193.09	19309	0	0	0	0	0	193.09
200.00							200.00
201.00							201.00
202.00		1,267,593	1,992,240	547,322	14,984,991	1,050,862	202.00
203.00		21.232714	4.178689	54.732200	149,849.910000	0.002341	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140002

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

Worksheet B-1

Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description		CAFETERIA (FTE'S)	NURSING ADMINISTRATION  (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIREMENTS)	PHARMACY (COSTED REQUIREMENTS)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	260,859	166,052	147,321	779,151	152,656	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.083183	0.348291	14.732100	7,791.510000	0.000340	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140002

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

Worksheet B-1  
Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description		SOCIAL SERVICE (PATIENT DAYS) 17.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
4.03	00401	ADMITTING	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
44.00	04400	SKILLED NURSING FACILITY	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03020	ONCOLOGY	76.00
76.01	03340	GASTROINTESTINAL SERVICES	76.01
76.02	03550	OP PSYCH	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00	09500	AMBULANCE SERVICES	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	TWIN RIVERS MRI	192.01
193.00	19300	NONPAID WORKERS	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	193.01
193.02	19302	MEDICAL OFFICE BUILDING	193.02
193.03	19303	HOME CARE PHARMACY	193.03
193.04	19304	MANAGEMENT SERVICES	193.04
193.05	19305	EUNICE SMITH NURSING HOME	193.05
193.06	19306	VACANT SPACE	193.06
193.07	19307	POB 2	193.07
193.08	19308	NON REIMBURSABLE MEALS	193.08
193.09	19309	COFFEE BAR	193.09
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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet B-1 Date/Time Prepared: 5/23/2016 1:51 pm
Cost Center Description		SOCIAL SERVICE (PATIENT DAYS) 17.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	2.569367	205.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/23/2016 1:51 pm		
		Title XVIIII	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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		20,854,842	0	20,854,842	30.00
31.00	03100 INTENSIVE CARE UNIT		4,070,072	0	4,070,072	31.00
40.00	04000 SUBPROVIDER - IPF		2,692,244	0	2,692,244	40.00
44.00	04400 SKILLED NURSING FACILITY		3,061,925	0	3,061,925	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		7,814,030	0	7,814,030	50.00
51.00	05100 RECOVERY ROOM		1,139,074	0	1,139,074	51.00
53.00	05300 ANESTHESIOLOGY		533,877	0	533,877	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,334,504	0	5,334,504	54.00
56.00	05600 RADIOISOTOPE		661,288	0	661,288	56.00
57.00	05700 CT SCAN		906,639	0	906,639	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		530,032	0	530,032	58.00
59.00	05900 CARDIAC CATHETERIZATION		1,297,925	0	1,297,925	59.00
60.00	06000 LABORATORY		5,104,734	0	5,104,734	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		1,741,860	0	1,741,860	63.00
65.00	06500 RESPIRATORY THERAPY	0	1,595,427	0	1,595,427	65.00
66.00	06600 PHYSICAL THERAPY	0	2,173,588	0	2,173,588	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	453,715	0	453,715	67.00
68.00	06800 SPEECH PATHOLOGY	0	285,749	0	285,749	68.00
69.00	06900 ELECTROCARDIOLOGY		2,066,778	0	2,066,778	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		3,287,548	0	3,287,548	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		10,224,480	0	10,224,480	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		15,340,840	0	15,340,840	73.00
74.00	07400 RENAL DIALYSIS		510,566	0	510,566	74.00
76.00	03020 ONCOLOGY		1,425,112	0	1,425,112	76.00
76.01	03340 GASTROINTESTINAL SERVICES		1,862,743	0	1,862,743	76.01
76.02	03550 OP PSYCH		820,178	0	820,178	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY		342,895	0	342,895	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100 EMERGENCY		6,344,399	0	6,344,399	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,289,995	0	1,289,995	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES		4,175,026	0	4,175,026	95.00
200.00	Subtotal (see instructions)	0	107,942,085	0	107,942,085	200.00
201.00	Less Observation Beds		1,289,995		1,289,995	201.00
202.00	Total (see instructions)	0	106,652,090	0	106,652,090	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/23/2016 1:51 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	32,630,018		32,630,018			30.00
31.00 03100 INTENSIVE CARE UNIT	7,898,704		7,898,704			31.00
40.00 04000 SUBPROVIDER - IPF	3,572,455		3,572,455			40.00
44.00 04400 SKILLED NURSING FACILITY	3,398,853		3,398,853			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	8,236,926	18,685,854	26,922,780	0.290239	0.000000	50.00
51.00 05100 RECOVERY ROOM	1,133,024	4,066,156	5,199,180	0.219087	0.000000	51.00
53.00 05300 ANESTHESIOLOGY	3,223,435	5,722,565	8,946,000	0.059678	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	5,101,666	27,676,249	32,777,915	0.162747	0.000000	54.00
56.00 05600 RADIOISOTOPE	869,396	3,395,295	4,264,691	0.155061	0.000000	56.00
57.00 05700 CT SCAN	8,567,127	29,174,232	37,741,359	0.024022	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,306,470	4,175,078	5,481,548	0.096694	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	3,596,496	5,849,776	9,446,272	0.137401	0.000000	59.00
60.00 06000 LABORATORY	20,367,489	29,358,240	49,725,729	0.102658	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	2,677,947	2,204,380	4,882,327	0.356768	0.000000	63.00
65.00 06500 RESPIRATORY THERAPY	6,684,006	737,653	7,421,659	0.214969	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	3,078,870	5,943,760	9,022,630	0.240904	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	1,484,124	578,503	2,062,627	0.219969	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	230,465	686,090	916,555	0.311764	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	6,479,855	13,906,323	20,386,178	0.101381	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,515,189	6,275,724	11,790,913	0.278820	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	14,655,983	11,502,649	26,158,632	0.390864	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	20,249,789	37,220,087	57,469,876	0.266937	0.000000	73.00
74.00 07400 RENAL DIALYSIS	1,292,114	40,464	1,332,578	0.383142	0.000000	74.00
76.00 03020 ONCOLOGY	14,810	2,996,972	3,011,782	0.473179	0.000000	76.00
76.01 03340 GASTROINTESTINAL SERVICES	1,183,803	9,683,989	10,867,792	0.171400	0.000000	76.01
76.02 03550 OP PSYCH	3,547	2,375,333	2,378,880	0.344775	0.000000	76.02
76.98 07698 HYPERBARIC OXYGEN THERAPY	14,944	1,836,711	1,851,655	0.185183	0.000000	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100 EMERGENCY	9,657,016	34,419,493	44,076,509	0.143941	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	166,518	1,047,114	1,213,632	1.062921	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	6,194	16,046,731	16,052,925	0.260079	0.000000	95.00
200.00	Subtotal (see instructions)	173,297,233	275,605,421	448,902,654		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	173,297,233	275,605,421	448,902,654		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/23/2016 1:51 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
44.00	04400 SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.290239		50.00
51.00	05100 RECOVERY ROOM	0.219087		51.00
53.00	05300 ANESTHESIOLOGY	0.059678		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162747		54.00
56.00	05600 RADIOISOTOPE	0.155061		56.00
57.00	05700 CT SCAN	0.024022		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.096694		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.137401		59.00
60.00	06000 LABORATORY	0.102658		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.356768		63.00
65.00	06500 RESPIRATORY THERAPY	0.214969		65.00
66.00	06600 PHYSICAL THERAPY	0.240904		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.219969		67.00
68.00	06800 SPEECH PATHOLOGY	0.311764		68.00
69.00	06900 ELECTROCARDIOLOGY	0.101381		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.278820		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.390864		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.266937		73.00
74.00	07400 RENAL DIALYSIS	0.383142		74.00
76.00	03020 ONCOLOGY	0.473179		76.00
76.01	03340 GASTROINTESTINAL SERVICES	0.171400		76.01
76.02	03550 OP PSYCH	0.344775		76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.185183		76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100 EMERGENCY	0.143941		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.062921		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.260079		95.00
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: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/23/2016 1:51 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		20,854,842	0	20,854,842	30.00
31.00	03100 INTENSIVE CARE UNIT		4,070,072	0	4,070,072	31.00
40.00	04000 SUBPROVIDER - IPF		2,692,244	0	2,692,244	40.00
44.00	04400 SKILLED NURSING FACILITY		3,061,925	0	3,061,925	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		7,814,030	0	7,814,030	50.00
51.00	05100 RECOVERY ROOM		1,139,074	0	1,139,074	51.00
53.00	05300 ANESTHESIOLOGY		533,877	0	533,877	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,334,504	0	5,334,504	54.00
56.00	05600 RADIOISOTOPE		661,288	0	661,288	56.00
57.00	05700 CT SCAN		906,639	0	906,639	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		530,032	0	530,032	58.00
59.00	05900 CARDIAC CATHETERIZATION		1,297,925	0	1,297,925	59.00
60.00	06000 LABORATORY		5,104,734	0	5,104,734	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		1,741,860	0	1,741,860	63.00
65.00	06500 RESPIRATORY THERAPY	0	1,595,427	0	1,595,427	65.00
66.00	06600 PHYSICAL THERAPY	0	2,173,588	0	2,173,588	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	453,715	0	453,715	67.00
68.00	06800 SPEECH PATHOLOGY	0	285,749	0	285,749	68.00
69.00	06900 ELECTROCARDIOLOGY		2,066,778	0	2,066,778	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		3,287,548	0	3,287,548	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		10,224,480	0	10,224,480	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		15,340,840	0	15,340,840	73.00
74.00	07400 RENAL DIALYSIS		510,566	0	510,566	74.00
76.00	03020 ONCOLOGY		1,425,112	0	1,425,112	76.00
76.01	03340 GASTROINTESTINAL SERVICES		1,862,743	0	1,862,743	76.01
76.02	03550 OP PSYCH		820,178	0	820,178	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY		342,895	0	342,895	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100 EMERGENCY		6,344,399	0	6,344,399	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,289,995	0	1,289,995	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES		4,175,026	0	4,175,026	95.00
200.00	Subtotal (see instructions)	0	107,942,085	0	107,942,085	200.00
201.00	Less Observation Beds		1,289,995		1,289,995	201.00
202.00	Total (see instructions)	0	106,652,090	0	106,652,090	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/23/2016 1:51 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	10.00					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	32,630,018		32,630,018	30.00
31.00	03100	INTENSIVE CARE UNIT	7,898,704		7,898,704	31.00
40.00	04000	SUBPROVIDER - IPF	3,572,455		3,572,455	40.00
44.00	04400	SKILLED NURSING FACILITY	3,398,853		3,398,853	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	8,236,926	18,685,854	26,922,780	0.290239 50.00
51.00	05100	RECOVERY ROOM	1,133,024	4,066,156	5,199,180	0.219087 51.00
53.00	05300	ANESTHESIOLOGY	3,223,435	5,722,565	8,946,000	0.059678 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,101,666	27,676,249	32,777,915	0.162747 54.00
56.00	05600	RADIOISOTOPE	869,396	3,395,295	4,264,691	0.155061 56.00
57.00	05700	CT SCAN	8,567,127	29,174,232	37,741,359	0.024022 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,306,470	4,175,078	5,481,548	0.096694 58.00
59.00	05900	CARDIAC CATHETERIZATION	3,596,496	5,849,776	9,446,272	0.137401 59.00
60.00	06000	LABORATORY	20,367,489	29,358,240	49,725,729	0.102658 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,677,947	2,204,380	4,882,327	0.356768 63.00
65.00	06500	RESPIRATORY THERAPY	6,684,006	737,653	7,421,659	0.214969 65.00
66.00	06600	PHYSICAL THERAPY	3,078,870	5,943,760	9,022,630	0.240904 66.00
67.00	06700	OCCUPATIONAL THERAPY	1,484,124	578,503	2,062,627	0.219969 67.00
68.00	06800	SPEECH PATHOLOGY	230,465	686,090	916,555	0.311764 68.00
69.00	06900	ELECTROCARDIOLOGY	6,479,855	13,906,323	20,386,178	0.101381 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,515,189	6,275,724	11,790,913	0.278820 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,655,983	11,502,649	26,158,632	0.390864 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,249,789	37,220,087	57,469,876	0.266937 73.00
74.00	07400	RENAL DIALYSIS	1,292,114	40,464	1,332,578	0.383142 74.00
76.00	03020	ONCOLOGY	14,810	2,996,972	3,011,782	0.473179 76.00
76.01	03340	GASTROINTESTINAL SERVICES	1,183,803	9,683,989	10,867,792	0.171400 76.01
76.02	03550	OP PSYCH	3,547	2,375,333	2,378,880	0.344775 76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	14,944	1,836,711	1,851,655	0.185183 76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100	EMERGENCY	9,657,016	34,419,493	44,076,509	0.143941 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	166,518	1,047,114	1,213,632	1.062921 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	6,194	16,046,731	16,052,925	0.260079 95.00
200.00		Subtotal (see instructions)	173,297,233	275,605,421	448,902,654	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	173,297,233	275,605,421	448,902,654	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/23/2016 1:51 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital PPS
INPATIENT ROUTINE SERVICE COST CENTERS		11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.290239		50.00
51.00	05100 RECOVERY ROOM	0.219087		51.00
53.00	05300 ANESTHESIOLOGY	0.059678		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162747		54.00
56.00	05600 RADIOISOTOPE	0.155061		56.00
57.00	05700 CT SCAN	0.024022		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.096694		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.137401		59.00
60.00	06000 LABORATORY	0.102658		60.00
63.00	06300 BLOOD STORAGE, PROCESSING & TRANS.	0.356768		63.00
65.00	06500 RESPIRATORY THERAPY	0.214969		65.00
66.00	06600 PHYSICAL THERAPY	0.240904		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.219969		67.00
68.00	06800 SPEECH PATHOLOGY	0.311764		68.00
69.00	06900 ELECTROCARDIOLOGY	0.101381		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.278820		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.390864		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.266937		73.00
74.00	07400 RENAL DIALYSIS	0.383142		74.00
76.00	03020 ONCOLOGY	0.473179		76.00
76.01	03340 GASTROINTESTINAL SERVICES	0.171400		76.01
76.02	03550 OP PSYCH	0.344775		76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.185183		76.98
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.143941		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.062921		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.260079		95.00
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: 140002

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

Worksheet C Part II Date/Time Prepared: 5/23/2016 1:51 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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	7,814,030	932,274	6,881,756	0	0	50.00
51.00	05100 RECOVERY ROOM	1,139,074	111,026	1,028,048	0	0	51.00
53.00	05300 ANESTHESIOLOGY	533,877	97,419	436,458	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,334,504	853,246	4,481,258	0	0	54.00
56.00	05600 RADIO SOTOPE	661,288	47,578	613,710	0	0	56.00
57.00	05700 CT SCAN	906,639	62,992	843,647	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	530,032	63,032	467,000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,297,925	116,545	1,181,380	0	0	59.00
60.00	06000 LABORATORY	5,104,734	612,185	4,492,549	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1,741,860	82,981	1,658,879	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	1,595,427	127,934	1,467,493	0	0	65.00
66.00	06600 PHYSICAL THERAPY	2,173,588	218,547	1,955,041	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	453,715	50,333	403,382	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	285,749	21,165	264,584	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	2,066,778	263,800	1,802,978	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,287,548	167,108	3,120,440	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	10,224,480	501,127	9,723,353	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15,340,840	817,012	14,523,828	0	0	73.00
74.00	07400 RENAL DIALYSIS	510,566	25,560	485,006	0	0	74.00
76.00	03020 ONCOLOGY	1,425,112	108,973	1,316,139	0	0	76.00
76.01	03340 GASTRO INTESTINAL SERVICES	1,862,743	274,976	1,587,767	0	0	76.01
76.02	03550 OP PSYCH	820,178	131,379	688,799	0	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	342,895	14,338	328,557	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	6,344,399	652,871	5,691,528	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,289,995	154,060	1,135,935	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	4,175,026	412,503	3,762,523	0	0	95.00
200.00	Subtotal (sum of lines 50 thru 199)	77,263,002	6,920,964	70,342,038	0	0	200.00
201.00	Less Observation Beds	1,289,995	154,060	1,135,935	0	0	201.00
202.00	Total (Line 200 minus Line 201)	75,973,007	6,766,904	69,206,103	0	0	202.00

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

Provider CCN: 140002

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

Worksheet C Part II Date/Time Prepared: 5/23/2016 1:51 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	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	7,814,030	26,922,780	0.290239	50.00
51.00	05100 RECOVERY ROOM	1,139,074	5,199,180	0.219087	51.00
53.00	05300 ANESTHESIOLOGY	533,877	8,946,000	0.059678	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,334,504	32,777,915	0.162747	54.00
56.00	05600 RADIOISOTOPE	661,288	4,264,691	0.155061	56.00
57.00	05700 CT SCAN	906,639	37,741,359	0.024022	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	530,032	5,481,548	0.096694	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,297,925	9,446,272	0.137401	59.00
60.00	06000 LABORATORY	5,104,734	49,725,729	0.102658	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1,741,860	4,882,327	0.356768	63.00
65.00	06500 RESPIRATORY THERAPY	1,595,427	7,421,659	0.214969	65.00
66.00	06600 PHYSICAL THERAPY	2,173,588	9,022,630	0.240904	66.00
67.00	06700 OCCUPATIONAL THERAPY	453,715	2,062,627	0.219969	67.00
68.00	06800 SPEECH PATHOLOGY	285,749	916,555	0.311764	68.00
69.00	06900 ELECTROCARDIOLOGY	2,066,778	20,386,178	0.101381	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,287,548	11,790,913	0.278820	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	10,224,480	26,158,632	0.390864	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15,340,840	57,469,876	0.266937	73.00
74.00	07400 RENAL DIALYSIS	510,566	1,332,578	0.383142	74.00
76.00	03020 ONCOLOGY	1,425,112	3,011,782	0.473179	76.00
76.01	03340 GASTRO INTESTINAL SERVICES	1,862,743	10,867,792	0.171400	76.01
76.02	03550 OP PSYCH	820,178	2,378,880	0.344775	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	342,895	1,851,655	0.185183	76.98
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	6,344,399	44,076,509	0.143941	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,289,995	1,213,632	1.062921	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	4,175,026	16,052,925	0.260079	95.00
200.00	Subtotal (sum of lines 50 thru 199)	77,263,002	401,402,624		200.00
201.00	Less Observation Beds	1,289,995	0		201.00
202.00	Total (line 200 minus line 201)	75,973,007	401,402,624		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140002		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part I Date/Time Prepared: 5/23/2016 1:51 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	2,490,629	0	2,490,629	22,698	109.73	30.00
31.00	INTENSIVE CARE UNIT	353,334	0	353,334	2,625	134.60	31.00
40.00	SUBPROVIDER - IPF	264,254	0	264,254	2,946	89.70	40.00
44.00	SKILLED NURSING FACILITY	231,311		231,311	4,596	50.33	44.00
200.00	Total (lines 30-199)	3,339,528		3,339,528	32,865		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	9,744	1,069,209				
31.00	INTENSIVE CARE UNIT	1,205	162,193				
40.00	SUBPROVIDER - IPF	2,587	232,054				
44.00	SKILLED NURSING FACILITY	2,995	150,738				
200.00	Total (lines 30-199)	16,531	1,614,194				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140002

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

Worksheet D  
Part II  
Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	932,274	26,922,780	0.034628	4,304,809	149,067	50.00
51.00	05100	RECOVERY ROOM	111,026	5,199,180	0.021355	511,869	10,931	51.00
53.00	05300	ANESTHESIOLOGY	97,419	8,946,000	0.010890	1,411,229	15,368	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	853,246	32,777,915	0.026031	1,890,918	49,222	54.00
56.00	05600	RADIOISOTOPE	47,578	4,264,691	0.011156	342,172	3,817	56.00
57.00	05700	CT SCAN	62,992	37,741,359	0.001669	3,937,312	6,571	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	63,032	5,481,548	0.011499	595,899	6,852	58.00
59.00	05900	CARDIAC CATHETERIZATION	116,545	9,446,272	0.012338	1,027,767	12,681	59.00
60.00	06000	LABORATORY	612,185	49,725,729	0.012311	9,596,539	118,143	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	82,981	4,882,327	0.016996	789,623	13,420	63.00
65.00	06500	RESPIRATORY THERAPY	127,934	7,421,659	0.017238	3,422,541	58,998	65.00
66.00	06600	PHYSICAL THERAPY	218,547	9,022,630	0.024222	897,314	21,735	66.00
67.00	06700	OCCUPATIONAL THERAPY	50,333	2,062,627	0.024402	187,156	4,567	67.00
68.00	06800	SPEECH PATHOLOGY	21,165	916,555	0.023092	118,033	2,726	68.00
69.00	06900	ELECTROCARDIOLOGY	263,800	20,386,178	0.012940	4,094,823	52,987	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	167,108	11,790,913	0.014173	2,651,864	37,585	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	501,127	26,158,632	0.019157	6,762,709	129,553	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	817,012	57,469,876	0.014216	10,767,144	153,066	73.00
74.00	07400	RENAL DIALYSIS	25,560	1,332,578	0.019181	712,237	13,661	74.00
76.00	03020	ONCOLOGY	108,973	3,011,782	0.036182	2,900	105	76.00
76.01	03340	GASTROINTESTINAL SERVICES	274,976	10,867,792	0.025302	529,600	13,400	76.01
76.02	03550	OP PSYCH	131,379	2,378,880	0.055227	2,198	121	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	14,338	1,851,655	0.007743	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	652,871	44,076,509	0.014812	3,263,740	48,343	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	154,060	1,213,632	0.126941	94,345	11,976	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	6,508,461	385,349,699		57,914,741	934,895	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part III Date/Time Prepared: 5/23/2016 1:51 pm
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Cost Center Description			Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0 40.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00	
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)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,698	0.00	9,744	0	0 30.00	
31.00	03100	INTENSIVE CARE UNIT	2,625	0.00	1,205	0	0 31.00	
40.00	04000	SUBPROVIDER - IPF	2,946	0.00	2,587	0	0 40.00	
44.00	04400	SKILLED NURSING FACILITY	4,596	0.00	2,995	0	0 44.00	
200.00		Total (lines 30-199)	32,865		16,531	0	0 200.00	
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
			12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				
31.00	03100	INTENSIVE CARE UNIT	0	0				
40.00	04000	SUBPROVIDER - IPF	0	0				
44.00	04400	SKILLED NURSING FACILITY	0	0				
200.00		Total (lines 30-199)	0	0				

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140002

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY	0	0	0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>									
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (Lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140002

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/23/2016 1:51 pm

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		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	26,922,780	0.000000	0.000000	4,304,809	50.00
51.00	05100	RECOVERY ROOM	0	5,199,180	0.000000	0.000000	511,869	51.00
53.00	05300	ANESTHESIOLOGY	0	8,946,000	0.000000	0.000000	1,411,229	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,777,915	0.000000	0.000000	1,890,918	54.00
56.00	05600	RADIOISOTOPE	0	4,264,691	0.000000	0.000000	342,172	56.00
57.00	05700	CT SCAN	0	37,741,359	0.000000	0.000000	3,937,312	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,481,548	0.000000	0.000000	595,899	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,446,272	0.000000	0.000000	1,027,767	59.00
60.00	06000	LABORATORY	0	49,725,729	0.000000	0.000000	9,596,539	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	4,882,327	0.000000	0.000000	789,623	63.00
65.00	06500	RESPIRATORY THERAPY	0	7,421,659	0.000000	0.000000	3,422,541	65.00
66.00	06600	PHYSICAL THERAPY	0	9,022,630	0.000000	0.000000	897,314	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,062,627	0.000000	0.000000	187,156	67.00
68.00	06800	SPEECH PATHOLOGY	0	916,555	0.000000	0.000000	118,033	68.00
69.00	06900	ELECTROCARDIOLOGY	0	20,386,178	0.000000	0.000000	4,094,823	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,790,913	0.000000	0.000000	2,651,864	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	26,158,632	0.000000	0.000000	6,762,709	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	57,469,876	0.000000	0.000000	10,767,144	73.00
74.00	07400	RENAL DIALYSIS	0	1,332,578	0.000000	0.000000	712,237	74.00
76.00	03020	ONCOLOGY	0	3,011,782	0.000000	0.000000	2,900	76.00
76.01	03340	GASTROINTESTINAL SERVICES	0	10,867,792	0.000000	0.000000	529,600	76.01
76.02	03550	OP PSYCH	0	2,378,880	0.000000	0.000000	2,198	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	1,851,655	0.000000	0.000000	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	44,076,509	0.000000	0.000000	3,263,740	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,213,632	0.000000	0.000000	94,345	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	385,349,699			57,914,741	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/23/2016 1:51 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PPS
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	6,228,890	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	1,002,866	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	1,204,290	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	6,467,358	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	1,127,916	0	0	0	56.00
57.00	05700 CT SCAN	0	9,452,019	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,228,530	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	1,324,151	0	0	0	59.00
60.00	06000 LABORATORY	0	5,654,342	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	490,166	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	181,205	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	1,202	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	5,761,117	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,734,274	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	4,366,318	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	20,123,235	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 ONCOLOGY	0	625,595	0	0	0	76.00
76.01	03340 GASTROINTESTINAL SERVICES	0	2,727,181	0	0	0	76.01
76.02	03550 OP PSYCH	0	2,024,805	0	0	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	966,690	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	5,688,370	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	345,140	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	78,725,660	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/23/2016 1:51 pm
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	PPS
		23.00	24.00			
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0			50.00
51.00	05100 RECOVERY ROOM	0	0			51.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
56.00	05600 RADIOISOTOPE	0	0			56.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
74.00	07400 RENAL DIALYSIS	0	0			74.00
76.00	03020 ONCOLOGY	0	0			76.00
76.01	03340 GASTROINTESTINAL SERVICES	0	0			76.01
76.02	03550 OP PSYCH	0	0			76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0			76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/23/2016 1:51 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		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.290239	6,228,890	0	0	1,807,867	50.00
51.00	05100 RECOVERY ROOM	0.219087	1,002,866	0	0	219,715	51.00
53.00	05300 ANESTHESIOLOGY	0.059678	1,204,290	0	0	71,870	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162747	6,467,358	0	0	1,052,543	54.00
56.00	05600 RADIOISOTOPE	0.155061	1,127,916	0	0	174,896	56.00
57.00	05700 CT SCAN	0.024022	9,452,019	0	0	227,056	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.096694	1,228,530	0	0	118,791	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.137401	1,324,151	0	0	181,940	59.00
60.00	06000 LABORATORY	0.102658	5,654,342	0	0	580,463	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.356768	490,166	0	0	174,876	63.00
65.00	06500 RESPIRATORY THERAPY	0.214969	181,205	0	0	38,953	65.00
66.00	06600 PHYSICAL THERAPY	0.240904	1,202	0	0	290	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.219969	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.311764	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.101381	5,761,117	0	0	584,068	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.278820	1,734,274	0	0	483,550	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.390864	4,366,318	0	0	1,706,637	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.266937	20,123,235	0	8,038	5,371,636	73.00
74.00	07400 RENAL DIALYSIS	0.383142	0	0	0	0	74.00
76.00	03020 ONCOLOGY	0.473179	625,595	0	0	296,018	76.00
76.01	03340 GASTROINTESTINAL SERVICES	0.171400	2,727,181	0	0	467,439	76.01
76.02	03550 OP PSYCH	0.344775	2,024,805	0	0	698,102	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.185183	966,690	0	0	179,015	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	0.143941	5,688,370	0	0	818,790	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.062921	345,140	0	0	366,857	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0.260079		0			95.00
200.00	Subtotal (see instructions)		78,725,660	0	8,038	15,621,372	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		78,725,660	0	8,038	15,621,372	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/23/2016 1:51 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		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,146	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03020 ONCOLOGY	0	0	76.00
76.01	03340 GASTROINTESTINAL SERVICES	0	0	76.01
76.02	03550 OP PSYCH	0	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	0	2,146	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	2,146	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140002		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part II Date/Time Prepared: 5/23/2016 1:51 pm	
		Component CCN: 14S002		Title XVIII		Subprovider - IPF	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	932,274	26,922,780	0.034628	0	50.00
51.00	05100	RECOVERY ROOM	111,026	5,199,180	0.021355	0	51.00
53.00	05300	ANESTHESIOLOGY	97,419	8,946,000	0.010890	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	853,246	32,777,915	0.026031	42,789	1,114 54.00
56.00	05600	RADIOISOTOPE	47,578	4,264,691	0.011156	0	56.00
57.00	05700	CT SCAN	62,992	37,741,359	0.001669	164,431	274 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	63,032	5,481,548	0.011499	6,319	73 58.00
59.00	05900	CARDIAC CATHETERIZATION	116,545	9,446,272	0.012338	0	59.00
60.00	06000	LABORATORY	612,185	49,725,729	0.012311	468,881	5,772 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	82,981	4,882,327	0.016996	0	63.00
65.00	06500	RESPIRATORY THERAPY	127,934	7,421,659	0.017238	62,318	1,074 65.00
66.00	06600	PHYSICAL THERAPY	218,547	9,022,630	0.024222	20,864	505 66.00
67.00	06700	OCCUPATIONAL THERAPY	50,333	2,062,627	0.024402	1,674	41 67.00
68.00	06800	SPEECH PATHOLOGY	21,165	916,555	0.023092	2,996	69 68.00
69.00	06900	ELECTROCARDIOLOGY	263,800	20,386,178	0.012940	56,477	731 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	167,108	11,790,913	0.014173	18,570	263 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	501,127	26,158,632	0.019157	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	817,012	57,469,876	0.014216	351,231	4,993 73.00
74.00	07400	RENAL DIALYSIS	25,560	1,332,578	0.019181	0	74.00
76.00	03020	ONCOLOGY	108,973	3,011,782	0.036182	0	76.00
76.01	03340	GASTROINTESTINAL SERVICES	274,976	10,867,792	0.025302	0	76.01
76.02	03550	OP PSYCH	131,379	2,378,880	0.055227	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	14,338	1,851,655	0.007743	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	652,871	44,076,509	0.014812	208,090	3,082 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,213,632	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	6,354,401	385,349,699		1,404,640	17,991 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140002 Component CCN: 14S002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/23/2016 1:51 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	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
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 ONCOLOGY	0	0	0	0	0	76.00
76.01	03340 GASTROINTESTINAL SERVICES	0	0	0	0	0	76.01
76.02	03550 OP PSYCH	0	0	0	0	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
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: 140002 Component CCN: 14S002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/23/2016 1:51 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	26,922,780	0.000000	0.000000	0	50.00
51.00	05100 RECOVERY ROOM	0	5,199,180	0.000000	0.000000	0	51.00
53.00	05300 ANESTHESIOLOGY	0	8,946,000	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	32,777,915	0.000000	0.000000	42,789	54.00
56.00	05600 RADIOISOTOPE	0	4,264,691	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	37,741,359	0.000000	0.000000	164,431	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	5,481,548	0.000000	0.000000	6,319	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	9,446,272	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	49,725,729	0.000000	0.000000	468,881	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	4,882,327	0.000000	0.000000	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	7,421,659	0.000000	0.000000	62,318	65.00
66.00	06600 PHYSICAL THERAPY	0	9,022,630	0.000000	0.000000	20,864	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,062,627	0.000000	0.000000	1,674	67.00
68.00	06800 SPEECH PATHOLOGY	0	916,555	0.000000	0.000000	2,996	68.00
69.00	06900 ELECTROCARDIOLOGY	0	20,386,178	0.000000	0.000000	56,477	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,790,913	0.000000	0.000000	18,570	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	26,158,632	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	57,469,876	0.000000	0.000000	351,231	73.00
74.00	07400 RENAL DIALYSIS	0	1,332,578	0.000000	0.000000	0	74.00
76.00	03020 ONCOLOGY	0	3,011,782	0.000000	0.000000	0	76.00
76.01	03340 GASTROINTESTINAL SERVICES	0	10,867,792	0.000000	0.000000	0	76.01
76.02	03550 OP PSYCH	0	2,378,880	0.000000	0.000000	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	1,851,655	0.000000	0.000000	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	0	44,076,509	0.000000	0.000000	208,090	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,213,632	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	385,349,699			1,404,640	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140002 Component CCN: 14S002		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part IV Date/Time Prepared: 5/23/2016 1:51 pm	
				Title XVIII		Subprovider - IPF	
Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	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
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ONCOLOGY	0	0	0	0	76.00
76.01	03340	GASTROINTESTINAL SERVICES	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140002 Component CCN: 14S002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/23/2016 1:51 pm
Title XVII		Subprovider - IPF	PPS

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
	23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03020 ONCOLOGY	0	0	76.00
76.01 03340 GASTROINTESTINAL SERVICES	0	0	76.01
76.02 03550 OP PSYCH	0	0	76.02
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>			
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00 09500 AMBULANCE SERVICES			95.00
200.00 Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140002 Component CCN: 145566	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/23/2016 1:51 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	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
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 ONCOLOGY	0	0	0	0	0	76.00
76.01	03340 GASTROINTESTINAL SERVICES	0	0	0	0	0	76.01
76.02	03550 OP PSYCH	0	0	0	0	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
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: 140002 Component CCN: 145566	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/23/2016 1:51 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Total	Total	Ratio of Cost	Outpatient	Inpatient Program Charges	
	Outpatient Cost (sum of col. 2, 3 and 4)	Charges (from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)		
	6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	26,922,780	0.000000	0.000000	4,131	50.00
51.00 05100 RECOVERY ROOM	0	5,199,180	0.000000	0.000000	0	51.00
53.00 05300 ANESTHESIOLOGY	0	8,946,000	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	32,777,915	0.000000	0.000000	54,260	54.00
56.00 05600 RADIOISOTOPE	0	4,264,691	0.000000	0.000000	1,535	56.00
57.00 05700 CT SCAN	0	37,741,359	0.000000	0.000000	5,191	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	5,481,548	0.000000	0.000000	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	9,446,272	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	49,725,729	0.000000	0.000000	549,466	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	4,882,327	0.000000	0.000000	16,831	63.00
65.00 06500 RESPIRATORY THERAPY	0	7,421,659	0.000000	0.000000	458,127	65.00
66.00 06600 PHYSICAL THERAPY	0	9,022,630	0.000000	0.000000	974,200	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	2,062,627	0.000000	0.000000	774,928	67.00
68.00 06800 SPEECH PATHOLOGY	0	916,555	0.000000	0.000000	22,223	68.00
69.00 06900 ELECTROCARDIOLOGY	0	20,386,178	0.000000	0.000000	39,808	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,790,913	0.000000	0.000000	84,686	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	26,158,632	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	57,469,876	0.000000	0.000000	996,320	73.00
74.00 07400 RENAL DIALYSIS	0	1,332,578	0.000000	0.000000	289,184	74.00
76.00 03020 ONCOLOGY	0	3,011,782	0.000000	0.000000	0	76.00
76.01 03340 GASTROINTESTINAL SERVICES	0	10,867,792	0.000000	0.000000	5,517	76.01
76.02 03550 OP PSYCH	0	2,378,880	0.000000	0.000000	0	76.02
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	1,851,655	0.000000	0.000000	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100 EMERGENCY	0	44,076,509	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,213,632	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	385,349,699			4,276,407	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140002 Component CCN: 145566		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part IV Date/Time Prepared: 5/23/2016 1:51 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	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
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ONCOLOGY	0	0	0	0	76.00
76.01	03340	GASTROINTESTINAL SERVICES	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140002 Component CCN: 145566	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/23/2016 1:51 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03020 ONCOLOGY	0	0	76.00
76.01	03340 GASTROINTESTINAL SERVICES	0	0	76.01
76.02	03550 OP PSYCH	0	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140002		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part I Date/Time Prepared: 5/23/2016 1:51 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)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,490,629	0	2,490,629	22,698	109.73	30.00
31.00	INTENSIVE CARE UNIT	353,334	0	353,334	2,625	134.60	31.00
40.00	SUBPROVIDER - IPF	264,254	0	264,254	2,946	89.70	40.00
44.00	SKILLED NURSING FACILITY	231,311		231,311	4,596	50.33	44.00
200.00	Total (lines 30-199)	3,339,528		3,339,528	32,865		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,630	178,860				
31.00	INTENSIVE CARE UNIT	403	54,244				
40.00	SUBPROVIDER - IPF	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (lines 30-199)	2,033	233,104				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 5/23/2016 1:51 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)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	932,274	26,922,780	0.034628	879,384	30,451	50.00
51.00	05100 RECOVERY ROOM	111,026	5,199,180	0.021355	41,877	894	51.00
53.00	05300 ANESTHESIOLOGY	97,419	8,946,000	0.010890	125,535	1,367	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	853,246	32,777,915	0.026031	162,741	4,236	54.00
56.00	05600 RADIOISOTOPE	47,578	4,264,691	0.011156	25,639	286	56.00
57.00	05700 CT SCAN	62,992	37,741,359	0.001669	315,104	526	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	63,032	5,481,548	0.011499	57,898	666	58.00
59.00	05900 CARDIAC CATHETERIZATION	116,545	9,446,272	0.012338	252,131	3,111	59.00
60.00	06000 LABORATORY	612,185	49,725,729	0.012311	995,798	12,259	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	82,981	4,882,327	0.016996	216,797	3,685	63.00
65.00	06500 RESPIRATORY THERAPY	127,934	7,421,659	0.017238	183,464	3,163	65.00
66.00	06600 PHYSICAL THERAPY	218,547	9,022,630	0.024222	10,110	245	66.00
67.00	06700 OCCUPATIONAL THERAPY	50,333	2,062,627	0.024402	40,391	986	67.00
68.00	06800 SPEECH PATHOLOGY	21,165	916,555	0.023092	5,838	135	68.00
69.00	06900 ELECTROCARDIOLOGY	263,800	20,386,178	0.012940	202,747	2,624	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	167,108	11,790,913	0.014173	26,208	371	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	501,127	26,158,632	0.019157	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	817,012	57,469,876	0.014216	908,652	12,917	73.00
74.00	07400 RENAL DIALYSIS	25,560	1,332,578	0.019181	12,600	242	74.00
76.00	03020 ONCOLOGY	108,973	3,011,782	0.036182	805	29	76.00
76.01	03340 GASTROINTESTINAL SERVICES	274,976	10,867,792	0.025302	28,665	725	76.01
76.02	03550 OP PSYCH	131,379	2,378,880	0.055227	0	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	14,338	1,851,655	0.007743	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	652,871	44,076,509	0.014812	411,071	6,089	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	154,060	1,213,632	0.126941	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	6,508,461	385,349,699		4,903,455	85,007	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part III Date/Time Prepared: 5/23/2016 1:51 pm
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Cost Center Description			Title XIX		Hospital		PPS	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0 40.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00	
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)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,698	0.00	1,630	0	0 30.00	
31.00	03100	INTENSIVE CARE UNIT	2,625	0.00	403	0	0 31.00	
40.00	04000	SUBPROVIDER - IPF	2,946	0.00	0	0	0 40.00	
44.00	04400	SKILLED NURSING FACILITY	4,596	0.00	0	0	0 44.00	
200.00		Total (lines 30-199)	32,865		2,033	0	0 200.00	
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
			12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	40.00			
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00			
200.00		Total (lines 30-199)	0	0	200.00			

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140002

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/23/2016 1:51 pm

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		
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY	0	0	0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>									
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (Lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140002

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/23/2016 1:51 pm

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		Inpatient Program Charges	PPS
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	26,922,780	0.000000	0.000000	879,384	50.00
51.00	05100	RECOVERY ROOM	0	5,199,180	0.000000	0.000000	41,877	51.00
53.00	05300	ANESTHESIOLOGY	0	8,946,000	0.000000	0.000000	125,535	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,777,915	0.000000	0.000000	162,741	54.00
56.00	05600	RADIOISOTOPE	0	4,264,691	0.000000	0.000000	25,639	56.00
57.00	05700	CT SCAN	0	37,741,359	0.000000	0.000000	315,104	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,481,548	0.000000	0.000000	57,898	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,446,272	0.000000	0.000000	252,131	59.00
60.00	06000	LABORATORY	0	49,725,729	0.000000	0.000000	995,798	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	4,882,327	0.000000	0.000000	216,797	63.00
65.00	06500	RESPIRATORY THERAPY	0	7,421,659	0.000000	0.000000	183,464	65.00
66.00	06600	PHYSICAL THERAPY	0	9,022,630	0.000000	0.000000	10,110	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,062,627	0.000000	0.000000	40,391	67.00
68.00	06800	SPEECH PATHOLOGY	0	916,555	0.000000	0.000000	5,838	68.00
69.00	06900	ELECTROCARDIOLOGY	0	20,386,178	0.000000	0.000000	202,747	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,790,913	0.000000	0.000000	26,208	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	26,158,632	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	57,469,876	0.000000	0.000000	908,652	73.00
74.00	07400	RENAL DIALYSIS	0	1,332,578	0.000000	0.000000	12,600	74.00
76.00	03020	ONCOLOGY	0	3,011,782	0.000000	0.000000	805	76.00
76.01	03340	GASTROINTESTINAL SERVICES	0	10,867,792	0.000000	0.000000	28,665	76.01
76.02	03550	OP PSYCH	0	2,378,880	0.000000	0.000000	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	1,851,655	0.000000	0.000000	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	44,076,509	0.000000	0.000000	411,071	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,213,632	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	385,349,699			4,903,455	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140002

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/23/2016 1:51 pm

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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	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
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ONCOLOGY	0	0	0	0	76.00
76.01	03340	GASTROINTESTINAL SERVICES	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/23/2016 1:51 pm
	Title XIX	Hospital	PPS

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost		
	23.00	24.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03020 ONCOLOGY	0	0		76.00
76.01 03340 GASTROINTESTINAL SERVICES	0	0		76.01
76.02 03550 OP PSYCH	0	0		76.02
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500 AMBULANCE SERVICES				95.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/23/2016 1:51 pm
		Title XIX	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
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.290239	0	1,173,882	0	0 50.00
51.00 05100 RECOVERY ROOM	0.219087	0	239,448	0	0 51.00
53.00 05300 ANESTHESIOLOGY	0.059678	0	342,833	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.162747	0	1,594,602	0	0 54.00
56.00 05600 RADIOISOTOPE	0.155061	0	163,475	0	0 56.00
57.00 05700 CT SCAN	0.024022	0	1,546,292	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.096694	0	517,545	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.137401	0	107,431	0	0 59.00
60.00 06000 LABORATORY	0.102658	0	1,650,438	0	0 60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.356768	0	113,134	0	0 63.00
65.00 06500 RESPIRATORY THERAPY	0.214969	0	37,509	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.240904	0	220,567	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.219969	0	49,030	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.311764	0	72,309	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0.101381	0	642,495	0	0 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.278820	0	1,003,825	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.390864	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.266937	0	2,223,743	0	0 73.00
74.00 07400 RENAL DIALYSIS	0.383142	0	0	0	0 74.00
76.00 03020 ONCOLOGY	0.473179	0	121,915	0	0 76.00
76.01 03340 GASTROINTESTINAL SERVICES	0.171400	0	202,142	0	0 76.01
76.02 03550 OP PSYCH	0.344775	0	0	0	0 76.02
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.185183	0	0	0	0 76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00 09100 EMERGENCY	0.143941	0	3,108,641	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.062921	0	158,846	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 09500 AMBULANCE SERVICES	0.260079	0	1,081,647	0	0 95.00
200.00	Subtotal (see instructions)	0	16,371,749	0	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	0 201.00
202.00	Net Charges (line 200 +/- line 201)	0	16,371,749	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/23/2016 1:51 pm
		Title XIX	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		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	340,706	0	50.00
51.00	05100 RECOVERY ROOM	52,460	0	51.00
53.00	05300 ANESTHESIOLOGY	20,460	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	259,517	0	54.00
56.00	05600 RADIOISOTOPE	25,349	0	56.00
57.00	05700 CT SCAN	37,145	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	50,043	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	14,761	0	59.00
60.00	06000 LABORATORY	169,431	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	40,363	0	63.00
65.00	06500 RESPIRATORY THERAPY	8,063	0	65.00
66.00	06600 PHYSICAL THERAPY	53,135	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	10,785	0	67.00
68.00	06800 SPEECH PATHOLOGY	22,543	0	68.00
69.00	06900 ELECTROCARDIOLOGY	65,137	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	279,886	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	593,599	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03020 ONCOLOGY	57,688	0	76.00
76.01	03340 GASTRO INTESTINAL SERVICES	34,647	0	76.01
76.02	03550 OP PSYCH	0	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100 EMERGENCY	447,461	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	168,841	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	281,314		95.00
200.00	Subtotal (see instructions)	3,033,334	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	3,033,334	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/23/2016 1:51 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		22,698	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		22,698	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		21,294	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)		9,744	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
<b>SWING BED ADJUSTMENT</b>				
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)		20,854,842	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)		20,854,842	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		20,854,842	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		918.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,952,787	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		8,952,787	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/23/2016 1:51 pm
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	4,070,072	2,625	1,550.50	1,205	1,868,353 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)					12,004,587 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					22,825,727 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)					1,231,402 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					934,895 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,166,297 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					20,659,430 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					1,404 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					918.80 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,289,995 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140002		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/23/2016 1:51 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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,490,629	20,854,842	0.119427	1,289,995	154,060	90.00
91.00	Nursing School cost	0	20,854,842	0.000000	1,289,995	0	91.00
92.00	Allied health cost	0	20,854,842	0.000000	1,289,995	0	92.00
93.00	All other Medical Education	0	20,854,842	0.000000	1,289,995	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Component CCN: 14S002		Date/Time Prepared: 5/23/2016 1:51 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,946	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,946	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,946	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)		2,587	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,692,244	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,692,244	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,692,244	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		913.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,364,156	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)		2,364,156	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140002		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
		Component CCN: 14S002				Date/Time Prepared: 5/23/2016 1:51 pm	
		Title XVIII		Subprovider - IPF		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	0	0	0.00	0	0	43.00	
44.00	INTENSIVE CARE UNIT						44.00
45.00	CORONARY CARE UNIT						45.00
46.00	BURN INTENSIVE CARE UNIT						46.00
47.00	SURGICAL INTENSIVE CARE UNIT						47.00
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)				213,997	48.00	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				2,578,153	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)				232,054	50.00	
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				17,991	51.00	
52.00	Total Program excludable cost (sum of lines 50 and 51)				250,045	52.00	
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				2,328,108	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: 140002 Component CCN: 14S002		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/23/2016 1:51 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	264,254	2,692,244	0.098154	0	0	90.00
91.00	Nursing School cost	0	2,692,244	0.000000	0	0	91.00
92.00	Allied health cost	0	2,692,244	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,692,244	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Component CCN: 145566		Date/Time Prepared: 5/23/2016 1:51 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,596	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,596	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)		4,596	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)		2,995	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
<b>SWING BED ADJUSTMENT</b>				
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)		3,061,925	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)		3,061,925	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		3,061,925	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1	
		Component CCN: 145566		Date/Time Prepared: 5/23/2016 1:51 pm	
		Title XVIII	Skilled Nursing Facility	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				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)				48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				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)				50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				53.00
	TARGET AMOUNT AND LIMIT COMPUTATION				
54.00	Program discharges				54.00
55.00	Target amount per discharge				55.00
56.00	Target amount (line 54 x line 55)				56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				57.00
58.00	Bonus payment (see instructions)				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				59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				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)				61.00
62.00	Relief payment (see instructions)				62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				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)				64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				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)				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)				68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				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)				3,061,925 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				666.22 71.00
72.00	Program routine service cost (line 9 x line 71)				1,995,329 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				1,995,329 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)				0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0 80.00
81.00	Inpatient routine service cost per diem limitation				0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)				1,995,329 83.00
84.00	Program inpatient ancillary services (see instructions)				988,713 84.00
85.00	Utilization review - physician compensation (see instructions)				0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				2,984,042 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: 140002 Component CCN: 145566		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/23/2016 1:51 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/23/2016 1:51 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		22,698	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		22,698	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		21,294	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,630	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
<b>SWING BED ADJUSTMENT</b>				
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)		20,854,842	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)		20,854,842	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		20,854,842	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		918.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,497,644	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,497,644	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/23/2016 1:51 pm
Cost Center Description			Title XIX	Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	4,070,072	2,625	1,550.50	403	624,852
44.00	CORONARY CARE UNIT				43.00
45.00	BURN INTENSIVE CARE UNIT				44.00
46.00	SURGICAL INTENSIVE CARE UNIT				45.00
47.00	OTHER SPECIAL CARE (SPECIFY)				46.00
Cost Center Description					47.00
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				922,031
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				3,044,527
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				233,104
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				85,007
52.00	Total Program excludable cost (sum of lines 50 and 51)				318,111
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				2,726,416
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0
55.00	Target amount per discharge				0.00
56.00	Target amount (line 54 x line 55)				0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0
58.00	Bonus payment (see instructions)				0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00
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
62.00	Relief payment (see instructions)				0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				1,404
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				918.80
89.00	Observation bed cost (line 87 x line 88) (see instructions)				1,289,995

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140002		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/23/2016 1:51 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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,490,629	20,854,842	0.119427	1,289,995	154,060	90.00
91.00	Nursing School cost	0	20,854,842	0.000000	1,289,995	0	91.00
92.00	Allied health cost	0	20,854,842	0.000000	1,289,995	0	92.00
93.00	All other Medical Education	0	20,854,842	0.000000	1,289,995	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/23/2016 1:51 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		14,649,540		30.00
31.00	03100 INTENSIVE CARE UNIT		3,824,410		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.290239	4,304,809	1,249,423	50.00
51.00	05100 RECOVERY ROOM	0.219087	511,869	112,144	51.00
53.00	05300 ANESTHESIOLOGY	0.059678	1,411,229	84,219	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162747	1,890,918	307,741	54.00
56.00	05600 RADIOISOTOPE	0.155061	342,172	53,058	56.00
57.00	05700 CT SCAN	0.024022	3,937,312	94,582	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.096694	595,899	57,620	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.137401	1,027,767	141,216	59.00
60.00	06000 LABORATORY	0.102658	9,596,539	985,162	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.356768	789,623	281,712	63.00
65.00	06500 RESPIRATORY THERAPY	0.214969	3,422,541	735,740	65.00
66.00	06600 PHYSICAL THERAPY	0.240904	897,314	216,167	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.219969	187,156	41,169	67.00
68.00	06800 SPEECH PATHOLOGY	0.311764	118,033	36,798	68.00
69.00	06900 ELECTROCARDIOLOGY	0.101381	4,094,823	415,137	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.278820	2,651,864	739,393	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.390864	6,762,709	2,643,299	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.266937	10,767,144	2,874,149	73.00
74.00	07400 RENAL DIALYSIS	0.383142	712,237	272,888	74.00
76.00	03020 ONCOLOGY	0.473179	2,900	1,372	76.00
76.01	03340 GASTROINTESTINAL SERVICES	0.171400	529,600	90,773	76.01
76.02	03550 OP PSYCH	0.344775	2,198	758	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.185183	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	0.143941	3,263,740	469,786	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.062921	94,345	100,281	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		57,914,741	12,004,587	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)		57,914,741		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3	
		Component CCN: 14S002		Date/Time Prepared: 5/23/2016 1:51 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		3,138,674		40.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.290239	0	0	50.00
51.00	05100 RECOVERY ROOM	0.219087	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.059678	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162747	42,789	6,964	54.00
56.00	05600 RADIOISOTOPE	0.155061	0	0	56.00
57.00	05700 CT SCAN	0.024022	164,431	3,950	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.096694	6,319	611	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.137401	0	0	59.00
60.00	06000 LABORATORY	0.102658	468,881	48,134	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.356768	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.214969	62,318	13,396	65.00
66.00	06600 PHYSICAL THERAPY	0.240904	20,864	5,026	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.219969	1,674	368	67.00
68.00	06800 SPEECH PATHOLOGY	0.311764	2,996	934	68.00
69.00	06900 ELECTROCARDIOLOGY	0.101381	56,477	5,726	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.278820	18,570	5,178	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.390864	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.266937	351,231	93,757	73.00
74.00	07400 RENAL DIALYSIS	0.383142	0	0	74.00
76.00	03020 ONCOLOGY	0.473179	0	0	76.00
76.01	03340 GASTROINTESTINAL SERVICES	0.171400	0	0	76.01
76.02	03550 OP PSYCH	0.344775	0	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.185183	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	0.143941	208,090	29,953	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.062921	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		1,404,640	213,997	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)		1,404,640		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3
		Component CCN: 145566		Date/Time Prepared: 5/23/2016 1:51 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.290239	4,131	50.00
51.00	05100 RECOVERY ROOM	0.219087	0	51.00
53.00	05300 ANESTHESIOLOGY	0.059678	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162747	54,260	54.00
56.00	05600 RADIOISOTOPE	0.155061	1,535	56.00
57.00	05700 CT SCAN	0.024022	5,191	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.096694	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.137401	0	59.00
60.00	06000 LABORATORY	0.102658	549,466	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.356768	16,831	63.00
65.00	06500 RESPIRATORY THERAPY	0.214969	458,127	65.00
66.00	06600 PHYSICAL THERAPY	0.240904	974,200	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.219969	774,928	67.00
68.00	06800 SPEECH PATHOLOGY	0.311764	22,223	68.00
69.00	06900 ELECTROCARDIOLOGY	0.101381	39,808	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.278820	84,686	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.390864	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.266937	996,320	73.00
74.00	07400 RENAL DIALYSIS	0.383142	289,184	74.00
76.00	03020 ONCOLOGY	0.473179	0	76.00
76.01	03340 GASTROINTESTINAL SERVICES	0.171400	5,517	76.01
76.02	03550 OP PSYCH	0.344775	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.185183	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100 EMERGENCY	0.143941	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.062921	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50-94 and 96-98)		4,276,407	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)		4,276,407	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/23/2016 1:51 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		2,038,893		30.00
31.00	03100 INTENSIVE CARE UNIT		488,954		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.290239	879,384	255,232	50.00
51.00	05100 RECOVERY ROOM	0.219087	41,877	9,175	51.00
53.00	05300 ANESTHESIOLOGY	0.059678	125,535	7,492	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162747	162,741	26,486	54.00
56.00	05600 RADIOISOTOPE	0.155061	25,639	3,976	56.00
57.00	05700 CT SCAN	0.024022	315,104	7,569	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.096694	57,898	5,598	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.137401	252,131	34,643	59.00
60.00	06000 LABORATORY	0.102658	995,798	102,227	60.00
63.00	06300 BLOOD STORAGE, PROCESSING & TRANS.	0.356768	216,797	77,346	63.00
65.00	06500 RESPIRATORY THERAPY	0.214969	183,464	39,439	65.00
66.00	06600 PHYSICAL THERAPY	0.240904	10,110	2,436	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.219969	40,391	8,885	67.00
68.00	06800 SPEECH PATHOLOGY	0.311764	5,838	1,820	68.00
69.00	06900 ELECTROCARDIOLOGY	0.101381	202,747	20,555	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.278820	26,208	7,307	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.390864	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.266937	908,652	242,553	73.00
74.00	07400 RENAL DIALYSIS	0.383142	12,600	4,828	74.00
76.00	03020 ONCOLOGY	0.473179	805	381	76.00
76.01	03340 GASTROINTESTINAL SERVICES	0.171400	28,665	4,913	76.01
76.02	03550 OP PSYCH	0.344775	0	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.185183	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	0.143941	411,071	59,170	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.062921	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		4,903,455	922,031	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)		4,903,455		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/23/2016 1:51 pm
		Title XVIII	Hospital	PPS
		0	1.00	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		15,538,370	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,883,812	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		63,896	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		128.15	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.31	30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.57	31.00
32.00	Sum of lines 30 and 31		22.88	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.09	33.00
34.00	Disproportionate share adjustment (see instructions)		413,039	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/23/2016 1:51 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			1.00	2.00	
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		954,158	787,614	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		713,658	197,979	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		911,637		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		21,810,754		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		21,810,754		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,713,478		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		23,524,232		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		23,524,232		61.00
62.00	Deductibles billed to program beneficiaries		2,487,048		62.00
63.00	Coinurance billed to program beneficiaries		23,940		63.00
64.00	Allowable bad debts (see instructions)		761,264		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		494,822		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		558,729		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		21,508,066		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		183,224		70.93
70.94	HRR adjustment amount (see instructions)		-159,117		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/23/2016 1:51 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		21,532,173		71.00
71.01	Sequestration adjustment (see instructions)		430,643		71.01
72.00	Interim payments		20,822,688		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		278,842		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		410,756		75.00
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140002		Period: From 01/01/2015 To 12/31/2015		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 5/23/2016 1:51 pm	
		PPS					
		Original .mcrcx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	3.31	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	19.57	0.00			19.57	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	22.88	0.00			19.57	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	128.15	0.00			128.15	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	8.09	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	3.31	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	3,290	0			3,290	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	644	0			644	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	42	0			42	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	15	0			15	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	689	0			689	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	4,680	0			4,680	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	23,919	0			23,919	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	23,919	0			23,919	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	19.57	0.00			19.57	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140002		Period: From 01/01/2015 To 12/31/2015		Worksheet DSH Date/Time Prepared: 5/23/2016 1:51 pm	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE</b>							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	8.09		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	True	29.00
30.00	Line 28 or 29 as applicable		8.09		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		8.09		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>DETERMINATION OF PROVIDER TYPE</b>							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet DSH Date/Time Prepared: 5/23/2016 1:51 pm
		Title XVIII	Hospital	PPS

		Revised Percentage 6.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	5.47	29.00
30.00	Line 28 or 29 as applicable	5.47	30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/23/2016 1:51 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		2,146	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		15,621,372	2.00
3.00	PPS payments		15,552,837	3.00
4.00	Outlier payment (see instructions)		16,128	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)		2,146	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		8,038	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)		8,038	14.00
<b>Customary charges</b>				
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)		8,038	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		5,892	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)		2,146	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)		15,568,965	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)		3,173,537	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)		12,397,574	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		12,397,574	30.00
31.00	Primary payer payments		3,802	31.00
32.00	Subtotal (line 30 minus line 31)		12,393,772	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		675,473	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		439,057	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		473,305	36.00
37.00	Subtotal (see instructions)		12,832,829	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)		12,832,829	40.00
40.01	Sequestration adjustment (see instructions)		256,657	40.01
41.00	Interim payments		12,587,413	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-11,241	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
				Overrides
				1.00
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	Override of Ancillary service charges (line 12)			0.112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140002

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/23/2016 1:51 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		20,822,688		12,520,313	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	07/06/2015	67,100	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		67,100	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)		20,822,688		12,587,413	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		278,842		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		11,241	6.02	
7.00	Total Medicare program liability (see instructions)		21,101,530		12,576,172	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140002  
Component CCN: 14S002

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/23/2016 1:51 pm

Title XVIII

Subprovider -  
IPF

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					0 1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2,010,809			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)					0 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)		2,010,809			0 4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					0 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)					0 6.00
6.01	SETTLEMENT TO PROVIDER		32,319			0 6.01
6.02	SETTLEMENT TO PROGRAM		0			0 6.02
7.00	Total Medicare program liability (see instructions)		2,043,128			0 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					0 8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140002  
Component CCN: 145566

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/23/2016 1:51 pm  
PPS

Title XVIII

Skilled Nursing Facility

		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		982,929		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		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)		982,929		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		4,419		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		987,348		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/23/2016 1:51 pm
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		6,935	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		10,949	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3,201	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		23,919	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		448,902,654	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6,534,194	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)		947,634	8.00
9.00	Sequestration adjustment amount (see instructions)		18,953	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		928,681	10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)		975,336	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)		-46,655	32.00
				Overrides
				1.00
<b>CONTRACTOR OVERRIDES</b>				
108.00	Override of HIT payment			0108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part II Date/Time Prepared: 5/23/2016 1:51 pm
		Component CCN: 14S002	Title XVII I	Subprovider - IPF
		PPS		
		1.00		
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		2,228,626	1.00
2.00	Net IPF PPS Outlier Payments		8,156	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		8.071233	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$ .		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		2,236,782	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		2,236,782	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		2,236,782	18.00
19.00	Deductibles		182,409	19.00
20.00	Subtotal (line 18 minus line 19)		2,054,373	20.00
21.00	Coinsurance		2,520	21.00
22.00	Subtotal (line 20 minus line 21)		2,051,853	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		50,725	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		32,971	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		33,559	25.00
26.00	Subtotal (sum of lines 22 and 24)		2,084,824	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		2,084,824	31.00
31.01	Sequestration adjustment (see instructions)		41,696	31.01
32.00	Interim payments		2,010,809	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)		32,319	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		8,156	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140002 Component CCN: 145566	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VI Date/Time Prepared: 5/23/2016 1:51 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		1,069,454	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,069,454	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		66,465	7.00
8.00	Allowable bad debts (see instructions)		6,937	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		4,509	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		1,007,498	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (see instructions)		1,007,498	15.00
15.01	Sequestration adjustment (see instructions)		20,150	15.01
16.00	Interim payments		982,929	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)		4,419	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 140002

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

Worksheet G

Date/Time Prepared:  
5/23/2016 1:51 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	506,583	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	19,672,451	0	0	0	4.00
5.00	Other receivable	1,080,413	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,212,534	0	0	0	6.00
7.00	Inventory	1,926,092	0	0	0	7.00
8.00	Prepaid expenses	64,762	0	0	0	8.00
9.00	Other current assets	1,279,881	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	21,317,648	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	177,167	0	0	0	12.00
13.00	Land improvements	5,757,596	0	0	0	13.00
14.00	Accumulated depreciation	-4,811,305	0	0	0	14.00
15.00	Buildings	92,562,895	0	0	0	15.00
16.00	Accumulated depreciation	-47,402,934	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	33,700,961	0	0	0	19.00
20.00	Accumulated depreciation	-27,933,238	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	61,402,317	0	0	0	23.00
24.00	Accumulated depreciation	-50,592,051	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	5,193,570	0	0	0	27.00
28.00	Accumulated depreciation	-1,975,950	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)	66,079,028	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	87,396,676	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	2,218,863	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,346,818	0	0	0	38.00
39.00	Payroll taxes payable	1,285,879	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	0	0	0	0	43.00
44.00	Other current liabilities	5,086,530	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,938,090	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
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	282,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	282,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,220,090	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	75,176,586				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	75,176,586	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	87,396,676	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140002

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

Worksheet G-1

Date/Time Prepared:  
5/23/2016 1:51 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		76,223,232		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		7,216,095			2.00
3.00	Total (sum of line 1 and line 2)		83,439,327		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00	CHANGE IN RESTRICTED ASSETS	28,865		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		28,865		0	10.00
11.00	Subtotal (line 3 plus line 10)		83,468,192		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00	TRANSFER TO BJC	8,291,606		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		8,291,606		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		75,176,586		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00	CHANGE IN RESTRICTED ASSETS		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	TRANSFER TO BJC		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: 140002

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/23/2016 1:51 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	32,630,018		32,630,018	1.00
2.00	SUBPROVIDER - IPF	3,572,455		3,572,455	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	3,398,853		3,398,853	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)	39,601,326		39,601,326	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	7,898,704		7,898,704	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)	7,898,704		7,898,704	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	47,500,030		47,500,030	17.00
18.00	Ancillary services	125,580,496	0	125,580,496	18.00
19.00	Outpatient services	0	261,875,246	261,875,246	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	6,194	16,046,731	16,052,925	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	173,086,720	277,921,977	451,008,697	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		127,565,748		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	NON OPERATING EXPENSES	1,332,165			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)		1,332,165		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		126,233,583		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140002

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

Worksheet G-3

Date/Time Prepared:  
5/23/2016 1:51 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	451,008,697	1.00
2.00	Less contractual allowances and discounts on patients' accounts	318,125,700	2.00
3.00	Net patient revenues (line 1 minus line 2)	132,882,997	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	126,233,583	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,649,414	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	7,597	6.00
7.00	Income from investments	183,254	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	820,686	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	135,356	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	MEANINGFUL USE MEDICAID	-79	24.00
24.01	MEANINGFUL USE MEDICARE	989,412	24.01
24.02	BJC OTHER OPERATING REVENUE	104,688	24.02
24.03	OTHER OPERATING REVENUE	5,087,005	24.03
25.00	Total other income (sum of lines 6-24)	7,327,919	25.00
26.00	Total (line 5 plus line 25)	13,977,333	26.00
27.00	PHYSICIAN PRACTICE OPERATIONS	7,667,417	27.00
27.01	PHYSICIAN OFFICE BUILDINGS	31,327	27.01
27.02	EUNICE SMITH NET INCOME	-178,879	27.02
27.03	TWIN RIVERS NET INCOME	-758,627	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	6,761,238	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,216,095	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140002	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/23/2016 1:51 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,623,593	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		12,927	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		65.53	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		3.31	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		19.57	8.00
9.00	Sum of lines 7 and 8		22.88	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.74	10.00
11.00	Disproportionate share adjustment (see instructions)		76,958	11.00
12.00	Total prospective capital payments (see instructions)		1,713,478	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00