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: 140013	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/18/2016 10:55 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/18/2016 Time: 10:55 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No. 06101
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 PROCTOR HOSPITAL (140013) 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	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-8,190	40,475	52,189	0	1.00
2.00	Subprovider - IPF	0	27,687	-16		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	629	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	20,126	40,459	52,189	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: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/18/2016 10:54 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 5409 N. KNOXVILLE	PO Box:			1.00
2.00	City: PEORIA	State: IL	Zip Code: 61614	County: PEORIA	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PROCTOR HOSPITAL	140013	37900	1	08/01/1996	N	P	P	3.00
4.00	Subprovider - IPF	PROCTOR HOSPITAL	14S013	37900	4	11/30/2012	N	P	P	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	PROCTOR HOSPITAL	145579	37900		11/03/1987	N	P	P	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: 1.00	To: 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.	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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.	126	590	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2016 10:54 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	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)				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2016 10:54 am

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

	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2016 10:54 am

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/18/2016 10:54 am

		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	992,777	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2016 10:54 am

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0721	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: PEORIA HOME OFFICE	Contractor's Name: NGS	Contractor's Number: 00131	141.00
142.00	Street: 221 NE GLEN OAK	PO Box:		142.00
143.00	City: PEORIA	State: IL	Zip Code: 61636	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.	N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	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	166.00

		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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	09/01/2015	11/29/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140013	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/18/2016 10:54 am

		1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 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: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/18/2016 10:54 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		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.			Y	15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	03/22/2016	Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/18/2016 10:54 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MONICA	SUTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	UNITYPOINT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	515-362-5144	MONICA.SUTTER@UNITYPOINT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/18/2016 10:54 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	03/22/2016			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		SENIOR REIMBURSEMENT ANALYST		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/18/2016 10:54 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P 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	145	52,925	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)		145	52,925	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	16	5,840	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		161	58,765	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	18	6,570		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	23	8,395		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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)		202				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: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/18/2016 10:54 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,286	655	13,457			1.00
2.00	HMO and other (see instructions)	3,518	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	7,286	655	13,457			7.00
8.00	INTENSIVE CARE UNIT	863	61	1,600			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		0	0			13.00
14.00	Total (see instructions)	8,149	716	15,057	0.00	504.88	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	3,280	0	4,579	0.00	27.68	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,912	0	6,373	0.00	25.36	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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	557.92	27.00
28.00	Observation Bed Days		232	2,341			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			87			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: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/18/2016 10:54 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,901	195	3,775	1.00
2.00	HMO and other (see instructions)			761	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	1,901	195	3,775	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	210	2	299	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	0.00					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: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/18/2016 10:54 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	27,165,722	0	27,165,722	1,114,281.00	24.38	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		264	0	264	4.00	66.00	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	1,162,121	-587,890	574,231	25,578.00	22.45	9.00
10.00	Excluded area salaries (see instructions)		3,124,398	286,551	3,410,949	167,930.00	20.31	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,240,125	0	1,240,125	30,855.00	40.19	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		31,400	0	31,400	396.00	79.29	13.00
14.00	Home office salaries & wage-related costs		6,748,227	0	6,748,227	162,430.00	41.55	14.00
15.00	Home office: Physician Part A - Administrative		518	0	518	3.00	172.67	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,200,102	0	7,200,102			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,265,401	0	1,265,401			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,855,837	0	1,855,837	81,184.00	22.86	27.00
28.00	Administrative & General under contract (see inst.)		1,972,762	0	1,972,762	10,716.00	184.09	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,111,934	0	1,111,934	48,627.00	22.87	30.00
31.00	Laundry & Linen Service	8.00	26,934	0	26,934	2,302.00	11.70	31.00
32.00	Housekeeping	9.00	724,843	0	724,843	55,794.00	12.99	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	900,841	-633,678	267,163	18,811.00	14.20	34.00
35.00	Dietary under contract (see instructions)		8,590	0	8,590	459.00	18.71	35.00
36.00	Cafeteria	11.00	0	347,127	347,127	24,437.00	14.20	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	298,258	0	298,258	17,368.00	17.17	39.00
40.00	Pharmacy	15.00	1,246,962	0	1,246,962	31,249.00	39.90	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/18/2016 10:54 am

		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	
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part III Date/Time Prepared: 5/18/2016 10:54 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		29,146,810	0	29,146,810	1,125,452.00	25.90	1.00
2.00	Excluded area salaries (see instructions)		4,286,519	-301,339	3,985,180	193,508.00	20.59	2.00
3.00	Subtotal salaries (line 1 minus line 2)		24,860,291	301,339	25,161,630	931,944.00	27.00	3.00
4.00	Subtotal other wages & related costs (see inst.)		8,020,270	0	8,020,270	193,684.00	41.41	4.00
5.00	Subtotal wage-related costs (see inst.)		7,200,102	0	7,200,102	0.00	28.62	5.00
6.00	Total (sum of lines 3 thru 5)		40,080,663	301,339	40,382,002	1,125,628.00	35.88	6.00
7.00	Total overhead cost (see instructions)		8,146,961	-286,551	7,860,410	290,947.00	27.02	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 5/18/2016 10:54 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	694,937	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)	2,204,535	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	180,910	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,261,437	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-101,102	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	57,194	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)	-6,152	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	114,843	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,986,407	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	30,981	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	41,513	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,465,503	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part V Date/Time Prepared: 5/18/2016 10:54 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	3,252,877	8,465,503	1.00
2.00	Hospital	3,252,877	8,295,301	2.00
3.00	Subprovider - IPF	0	85,740	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	84,462	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 140013	Period: From 01/01/2015 To 12/31/2015	Worksheet S-7 Date/Time Prepared: 5/18/2016 10:54 am

		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.	N		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	11	0	11	4.00
5.00		RVX	46	0	46	5.00
6.00		RVL	12	0	12	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	7	0	7	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	207	0	207	12.00
13.00		RUB	979	0	979	13.00
14.00		RUA	443	0	443	14.00
15.00		RVC	405	0	405	15.00
16.00		RVB	985	0	985	16.00
17.00		RVA	535	0	535	17.00
18.00		RHC	40	0	40	18.00
19.00		RHB	82	0	82	19.00
20.00		RHA	31	0	31	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	10	0	10	22.00
23.00		RMA	14	0	14	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	22	0	22	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	7	0	7	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	4	0	4	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	15	0	15	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	7	0	7	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	21	0	21	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	14	0	14	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-7 | Date/Time Prepared: 5/18/2016 10:54 am

		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	4	0	4	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	7	0	7	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	4	0	4	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		3,912	0	3,912	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	37900	37900	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	1,014,018	9.78	Y	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)	10,368,985			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-10 | Date/Time Prepared: 5/18/2016 10:54 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.200388	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,429,133	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	32,056,421	6.00
7.00	Medicaid cost (line 1 times line 6)	6,423,722	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)	3,994,589	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	565	9.00
10.00	Stand-alone SCHIP charges	9,972	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	1,998	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	1,433	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,996,022	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	386,406	402,309	788,715	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	77,431	80,618	158,049	21.00
22.00	Partial payment by patients approved for charity care	7,890	24,527	32,417	22.00
23.00	Cost of charity care (line 21 minus line 22)	69,541	56,091	125,632	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,568,795	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	223,330	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,345,465	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	870,779	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	996,411	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,992,433	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/18/2016 10:54 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,182,500	1,182,500	765,452	1,947,952	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	822,003	822,003	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,914,339	1,914,339	-24,337	1,890,002	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,855,837	2,469,606	4,325,443	-1,508,047	2,817,396	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,336,598	1,336,598	0	1,336,598	6.00
7.00	00700	OPERATION OF PLANT	1,111,934	3,021,243	4,133,177	-26	4,133,151	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,934	320,791	347,725	-82	347,643	8.00
9.00	00900	HOUSEKEEPING	724,843	340,441	1,065,284	-131	1,065,153	9.00
10.00	01000	DIETARY	900,841	610,632	1,511,473	-1,067,440	444,033	10.00
11.00	01100	CAFETERIA	0	0	0	582,426	582,426	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	-46,604	-46,604	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	298,258	634,993	933,251	-82,991	850,260	14.00
15.00	01500	PHARMACY	1,246,962	2,951,035	4,197,997	-2,608,015	1,589,982	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	-32,615	-32,615	16.00
17.00	01700	SOCIAL SERVICE	0	260	260	0	260	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,330,556	2,175,498	7,506,054	-2,358,439	5,147,615	30.00
31.00	03100	INTENSIVE CARE UNIT	1,210,434	409,185	1,619,619	-120,496	1,499,123	31.00
40.00	04000	SUBPROVIDER - IPF	1,171,087	881,658	2,052,745	-31,051	2,021,694	40.00
43.00	04300	NURSERY	0	10	10	0	10	43.00
44.00	04400	SKILLED NURSING FACILITY	1,162,121	1,032,215	2,194,336	-1,180,190	1,014,146	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,629,343	12,265,714	13,895,057	-9,285,325	4,609,732	50.00
51.00	05100	RECOVERY ROOM	1,035,786	267,825	1,303,611	-115,968	1,187,643	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	15	15	-15	0	52.00
53.00	05300	ANESTHESIOLOGY	50,966	286,887	337,853	-196,339	141,514	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,159,307	1,072,072	2,231,379	-211,569	2,019,810	54.00
57.00	05700	CT SCAN	288,460	243,897	532,357	-49,747	482,610	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	319,310	635,511	954,821	-36,308	918,513	58.00
60.00	06000	LABORATORY	1,252,861	1,764,308	3,017,169	-676,373	2,340,796	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	406,416	406,416	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,174,231	1,174,231	64.00
65.00	06500	RESPIRATORY THERAPY	748,833	316,311	1,065,144	178,198	1,243,342	65.00
66.00	06600	PHYSICAL THERAPY	0	623,471	623,471	658,884	1,282,355	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	273,383	273,383	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	103,066	103,066	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	169,185	63,958	233,143	-6,071	227,072	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,812,987	8,812,987	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,818,097	4,818,097	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,700,913	2,700,913	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	72,515	72,515	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	81,626	362,812	444,438	-78,601	365,837	76.02
76.03	03140	CARDIOLOGY	889,061	1,885,778	2,774,839	-1,721,772	1,053,067	76.03
76.97	07697	CARDIAC REHABILITATION	359,927	213,021	572,948	-135,672	437,276	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	424,545	917,991	1,342,536	859,900	2,202,436	90.00
91.00	09100	EMERGENCY	1,763,394	1,471,284	3,234,678	-1,135,036	2,099,642	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,212,411	41,671,859	66,884,270	-480,789	66,403,481	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	1,450	1,450	0	1,450	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	412,103	412,103	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	435,567	137,736	573,303	68,686	641,989	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	690,573	372,065	1,062,638	0	1,062,638	194.09
194.10	07960	ARC INGALLS	827,171	384,914	1,212,085	0	1,212,085	194.10
200.00		TOTAL (SUM OF LINES 118-199)	27,165,722	42,568,024	69,733,746	0	69,733,746	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/18/2016 10:54 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-300,844	1,647,108		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	822,003		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-938,684	951,318		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,372,643	15,190,039		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,336,598		6.00
7.00	00700	OPERATION OF PLANT	-35,305	4,097,846		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-8,289	339,354		8.00
9.00	00900	HOUSEKEEPING	0	1,065,153		9.00
10.00	01000	DIETARY	0	444,033		10.00
11.00	01100	CAFETERIA	0	582,426		11.00
13.00	01300	NURSING ADMINISTRATION	1,454,877	1,408,273		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	850,260		14.00
15.00	01500	PHARMACY	0	1,589,982		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	459,371	426,756		16.00
17.00	01700	SOCIAL SERVICE	0	260		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-107,120	5,040,495		30.00
31.00	03100	INTENSIVE CARE UNIT	-102,100	1,397,023		31.00
40.00	04000	SUBPROVIDER - IPF	-369,208	1,652,486		40.00
43.00	04300	NURSERY	0	10		43.00
44.00	04400	SKILLED NURSING FACILITY	-128	1,014,018		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,609,732		50.00
51.00	05100	RECOVERY ROOM	0	1,187,643		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-19,886	121,628		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-39,061	1,980,749		54.00
57.00	05700	CT SCAN	0	482,610		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	918,513		58.00
60.00	06000	LABORATORY	-12,587	2,328,209		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	406,416		63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,174,231		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,243,342		65.00
66.00	06600	PHYSICAL THERAPY	0	1,282,355		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	273,383		67.00
68.00	06800	SPEECH PATHOLOGY	0	103,066		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	227,072		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,812,987		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,818,097		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,700,913		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	72,515		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	365,837		76.02
76.03	03140	CARDIOLOGY	0	1,053,067		76.03
76.97	07697	CARDIAC REHABILITATION	-49,451	387,825		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-56,658	2,145,778		90.00
91.00	09100	EMERGENCY	-474,596	1,625,046		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,772,974	78,176,455		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	1,450		194.00
194.01	07951	MEALS ON WHEELS	0	0		194.01
194.02	07952	MARKETING	0	0		194.02
194.03	07953	GUEST MEALS	0	0		194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	412,103		194.04
194.05	07955	FOUNDATION	0	0		194.05
194.06	07956	DAYCARE CENTER	0	641,989		194.06
194.07	07957	UN-USED SQR FT - POB	0	0		194.07
194.08	07958	SENIOR SERVICES	0	0		194.08
194.09	07959	ARC BROMENN	0	1,062,638		194.09
194.10	07960	ARC INGALLS	0	1,212,085		194.10
200.00		TOTAL (SUM OF LINES 118-199)	11,772,974	81,506,720		200.00

RECLASSIFICATIONS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/18/2016 10:54 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	347,127	235,299		1.00
2.00	PHYSICIAN/OTHER MEALS	194.04	245,614	166,489		2.00
3.00	DAYCARE CENTER	194.06	40,937	27,749		3.00
	0		633,678	429,537		
	D - INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	72,930		1.00
	0		0	72,930		
	F - DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,700,913		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
	0		0	2,700,913		
	G - MED SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	8,812,987		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
	0		0	8,812,987		
	I - IMPLANTIBLE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,818,097		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	44		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
	0		0	4,818,141		

RECLASSIFICATIONS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/18/2016 10:54 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	J - BLOOD RECLASS					
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	0	367,480		1.00
	0		0	367,480		
	K - COST CENTER MAPPING					
1.00	ADULTS & PEDIATRICS	30.00	34,244	15,832		1.00
2.00	OPERATING ROOM	50.00	265,933	163,983		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	75,727	48,599		3.00
4.00	CT SCAN	57.00	6,245	14,862		4.00
5.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	23,908	15,028		5.00
6.00	INTRAVENOUS THERAPY	64.00	845,031	329,200		6.00
7.00	RESPIRATORY THERAPY	65.00	169,068	243,731		7.00
8.00	PHYSICAL THERAPY	66.00	489,335	374,760		8.00
9.00	OCCUPATIONAL THERAPY	67.00	79,812	193,571		9.00
10.00	SPEECH PATHOLOGY	68.00	18,744	84,322		10.00
11.00	PULMONARY FUNCTION TESTING	76.01	60,131	12,384		11.00
12.00	CARDIOLOGY	76.03	118,224	74,110		12.00
13.00	CLINIC	90.00	897,380	464,470		13.00
	0		3,083,782	2,034,852		
	M - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	692,522		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	822,003		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		0	1,514,525		
500.00	Grand Total: Increases		3,717,460	20,751,365		500.00

RECLASSIFICATIONS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/18/2016 10:54 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	633,678	429,537	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		633,678	429,537			
	D - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	72,930	12		1.00
	0		0	72,930			
	F - DRUGS RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		24,148	0		1.00
2.00	OPERATION OF PLANT	7.00	0	26	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	82	0		3.00
4.00	HOUSEKEEPING	9.00	0	29	0		4.00
5.00	DIETARY	10.00	0	4,225	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,551	0		6.00
7.00	PHARMACY	15.00	0	2,564,188	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	7,834	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	1,171	0		9.00
10.00	SUBPROVIDER - IPF	40.00	0	87	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	2,030	0		11.00
12.00	OPERATING ROOM	50.00	0	12,607	0		12.00
13.00	RECOVERY ROOM	51.00	0	4,111	0		13.00
14.00	ANESTHESIOLOGY	53.00	0	14,536	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,733	0		15.00
16.00	CT SCAN	57.00	0	15,556	0		16.00
17.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	8,656	0		17.00
18.00	LABORATORY	60.00	0	551	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	2,664	0		19.00
20.00	GASTRO INTESTINAL SERVICES	76.02	0	2,431	0		20.00
21.00	CARDIOLOGY	76.03	0	1,215	0		21.00
22.00	CARDIAC REHABILITATION	76.97	0	38	0		22.00
23.00	CLINIC	90.00	0	11,329	0		23.00
24.00	EMERGENCY	91.00	0	10,115	0		24.00
	0		0	2,700,913			
	G - MED SUPPLIES RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	73,687	0		1.00
2.00	PHARMACY	15.00	0	43,827	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	419,382	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	100,335	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	30,964	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	140,002	0		6.00
7.00	OPERATING ROOM	50.00	0	5,211,651	0		7.00
8.00	RECOVERY ROOM	51.00	0	107,442	0		8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	15	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	181,803	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	319,322	0		11.00
12.00	CT SCAN	57.00	0	55,141	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	6,545	0		13.00
14.00	LABORATORY	60.00	0	308,342	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	159,422	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	2,797	0		16.00
17.00	ELECTROENCEPHALOGRAPHY	70.00	0	6,071	0		17.00
18.00	GASTRO INTESTINAL SERVICES	76.02	0	76,170	0		18.00
19.00	CARDIOLOGY	76.03	0	978,553	0		19.00
20.00	CARDIAC REHABILITATION	76.97	0	4,530	0		20.00
21.00	CLINIC	90.00	0	193,240	0		21.00
22.00	EMERGENCY	91.00	0	393,746	0		22.00
	0		0	8,812,987			
	I - IMPLANTIBLE RECLASS						
1.00	HOUSEKEEPING	9.00	0	102	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,753	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	0	29	0		3.00
4.00	OPERATING ROOM	50.00	0	4,490,983	0		4.00
5.00	RECOVERY ROOM	51.00	0	4,415	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	174	0		6.00
7.00	CT SCAN	57.00	0	157	0		7.00
8.00	CARDIOLOGY	76.03	0	300,079	0		8.00
9.00	CLINIC	90.00	0	18,941	0		9.00
10.00	EMERGENCY	91.00	0	1,508	0		10.00
	0		0	4,818,141			

RECLASSIFICATIONS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/18/2016 10:54 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	J - BLOOD RECLASS						
1.00	LABORATORY	60.00	0	367,480	0		1.00
	0		0	367,480			
	K - COST CENTER MAPPING						
1.00	ADULTS & PEDIATRICS	30.00	1,401,456	579,887	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	15,136	3,854	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	587,890	450,239	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	8,501	2,165	0		4.00
5.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	6,245	14,862	0		5.00
6.00	RESPIRATORY THERAPY	65.00	60,131	12,384	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	202,414	0		7.00
8.00	CARDIOLOGY	76.03	388,258	246,001	0		8.00
9.00	CARDIAC REHABILITATION	76.97	83,022	48,082	0		9.00
10.00	CLINIC	90.00	84,631	193,809	0		10.00
11.00	EMERGENCY	91.00	448,512	281,155	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
	0		3,083,782	2,034,852			
	M - DEPRECIATION RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	189	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,435,117	9		2.00
3.00	NURSING ADMINISTRATION	13.00	0	46,604	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	32,615	0		4.00
	0		0	1,514,525			
500.00	Grand Total: Decreases		3,717,460	20,751,365			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I Date/Time Prepared: 5/18/2016 10:54 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,081,907	0	0	0	0	1.00
2.00	Land Improvements	6,382,159	0	0	0	0	2.00
3.00	Buildings and Fixtures	58,691,568	2,832,228	0	2,832,228	0	3.00
4.00	Building Improvements	429,739	0	0	0	429,739	4.00
5.00	Fixed Equipment	19,953,328	534	0	534	0	5.00
6.00	Movable Equipment	53,130,164	0	0	0	403,370	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	144,668,865	2,832,762	0	2,832,762	833,109	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	144,668,865	2,832,762	0	2,832,762	833,109	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	6,081,907	0	1.00
2.00	Land Improvements	6,382,159	0	2.00
3.00	Buildings and Fixtures	61,523,796	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	19,953,862	0	5.00
6.00	Movable Equipment	52,726,794	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	146,668,518	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	146,668,518	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/18/2016 10:54 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,182,500	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,182,500	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,182,500		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	1,182,500		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/18/2016 10:54 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	93,941,724	0	93,941,724	0.640504	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	52,726,794	0	52,726,794	0.359496	0	2.00
3.00	Total (sum of lines 1-2)	146,668,518	0	146,668,518	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,875,022	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	822,003	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,697,025	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	CAP REL COSTS-BLDG & FIXT	-300,844	72,930	0	0	1,647,108	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	822,003	2.00
3.00	Total (sum of lines 1-2)	-300,844	72,930	0	0	2,469,111	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/18/2016 10:54 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-48,366	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,170,770			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	15,047,994			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00			0		0.00	0	33.00
33.01	A&G - MISC REVENUE	B	-45,942	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/18/2016 10:54 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.03	PLANT OP OTHER REV	B	-64,158	OPERATION OF PLANT	7.00	0	33.03
33.04	LAUNDRY REVENUE	B	-8,289	LAUNDRY & LINEN SERVICE	8.00	0	33.04
33.08	MISC INCOME -A&P	B	-38,403	ADULTS & PEDIATRICS	30.00	0	33.08
33.09	LAB MISC REVENUE	B	-262	LABORATORY	60.00	0	33.09
33.10	RADIOLOGY - MISC REVENUE	B	-561	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.12	CARDIAC REHAB - MISC REV	B	-47,650	CARDIAC REHABILITATION	76.97	0	33.12
33.13	COUNSELING CTR MISC REV	B	-12,254	CLINIC	90.00	0	33.13
33.14	EMERGENCY ROOM - MISC REVENUE	B	-12,848	EMERGENCY	91.00	0	33.14
33.16			0		0.00	0	33.16
33.17			0		0.00	0	33.17
33.18	ADVERTISING A&P	A	-151,692	ADULTS & PEDIATRICS	30.00	0	33.18
33.19	ADVERTISING PSYCH	A	-125	SUBPROVIDER - IPF	40.00	0	33.19
33.20	ADVERTISING CLINIC	A	-641	CLINIC	90.00	0	33.20
33.21			0		0.00	0	33.21
33.31			0		0.00	0	33.31
33.32			0		0.00	0	33.32
33.37			0		0.00	0	33.37
33.39	INTEREST EXPENSE	A	-252,478	CAP REL COSTS-BLDG & FIXT	1.00	11	33.39
33.40	POB SECURITY COST	A	-10,454	OPERATION OF PLANT	7.00	0	33.40
33.41	POB SECURITY COST	A	-2,875	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.41
33.42			0		0.00	0	33.42
33.43			0		0.00	0	33.43
33.44	SELF FUNDED INSURANCE	A	-1,407,252	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45			0		0.00	0	33.45
33.46			0		0.00	0	33.46
33.47			0		0.00	0	33.47
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		11,772,974				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: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 5/18/2016 10:54 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	471,443	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOCATION	459,371	0	2.00
3.00	13.00	NURSING ADMINISTRATION	HOME OFFICE ALLOCATION	1,454,877	0	3.00
3.01	7.00	OPERATION OF PLANT	HOME OFFICE ALLOCATION	39,307	0	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	12,418,585	0	4.00
4.01	30.00	ADULTS & PEDIATRICS	HOME OFFICE ALLOCATION	204,411	0	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			15,047,994	0	5.00

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

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

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

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

6.00	B		100.00	UNITY POINT	100.00	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:					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: 140013	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-1 Date/Time Prepared: 5/18/2016 10:54 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	471,443	9		1.00
2.00	459,371	0		2.00
3.00	1,454,877	0		3.00
3.01	39,307	0		3.01
4.00	12,418,585	0		4.00
4.01	204,411	0		4.01
5.00	15,047,994			5.00

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

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

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

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

6.00	HEALTH SYSTEM		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: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/18/2016 10:54 am

	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	122,228	121,436	792	211,500	20	1.00
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	102,100	102,100	0	211,500	0	2.00
3.00	40.00	AGGREGATE-SUBPROVIDER - IPF	369,083	369,083	0	181,300	0	3.00
4.00	44.00	AGGREGATE-SKILLED NURSING FACILITY	128	128	0	211,500	0	4.00
5.00	53.00	AGGREGATE-ANESTHESIOLOGY	36,000	10,800	25,200	239,400	140	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	38,500	38,500	0	271,900	0	6.00
7.00	60.00	AGGREGATE-LABORATORY	12,325	12,325	0	260,300	0	7.00
8.00	76.97	AGGREGATE-CARDIAC REHABILITATION	1,801	1,801	0	211,500	0	8.00
9.00	90.00	AGGREGATE-CLINIC	44,513	43,763	750	211,500	25	9.00
10.00	91.00	AGGREGATE-EMERGENCY	466,406	461,748	4,658	211,500	212	10.00
200.00			1,193,084	1,161,684	31,400		397	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	2,034	102	0	0	0	1.00
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	44.00	AGGREGATE-SKILLED NURSING FACILITY	0	0	0	0	0	4.00
5.00	53.00	AGGREGATE-ANESTHESIOLOGY	16,114	806	0	0	0	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	7.00
8.00	76.97	AGGREGATE-CARDIAC REHABILITATION	0	0	0	0	0	8.00
9.00	90.00	AGGREGATE-CLINIC	2,542	127	0	0	0	9.00
10.00	91.00	AGGREGATE-EMERGENCY	21,557	1,078	0	0	0	10.00
200.00			42,247	2,113	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	2,034	0	121,436		1.00
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	102,100		2.00
3.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	369,083		3.00
4.00	44.00	AGGREGATE-SKILLED NURSING FACILITY	0	0	0	128		4.00
5.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	16,114	9,086	19,886		5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	38,500		6.00
7.00	60.00	AGGREGATE-LABORATORY	0	0	0	12,325		7.00
8.00	76.97	AGGREGATE-CARDIAC REHABILITATION	0	0	0	1,801		8.00
9.00	90.00	AGGREGATE-CLINIC	0	2,542	0	43,763		9.00
10.00	91.00	AGGREGATE-EMERGENCY	0	21,557	0	461,748		10.00
200.00			0	42,247	9,086	1,170,770		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/18/2016 10:54 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,647,108	1,647,108				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	822,003		822,003			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	951,318	48,609	24,259	1,024,186		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,190,039	166,235	82,961	69,995	15,509,230	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,336,598	272,634	136,058	0	1,745,290	6.00
7.00	00700	OPERATION OF PLANT	4,097,846	19,410	9,687	41,543	4,168,486	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	339,354	15,728	7,849	1,016	363,947	8.00
9.00	00900	HOUSEKEEPING	1,065,153	26,649	13,299	27,338	1,132,439	9.00
10.00	01000	DIETARY	444,033	20,877	10,419	10,076	485,405	10.00
11.00	01100	CAFETERIA	582,426	59,293	29,591	13,092	684,402	11.00
13.00	01300	NURSING ADMINISTRATION	1,408,273	9,556	4,769	0	1,422,598	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	850,260	0	0	11,249	861,509	14.00
15.00	01500	PHARMACY	1,589,982	13,471	6,723	47,030	1,657,206	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	426,756	0	0	0	426,756	16.00
17.00	01700	SOCIAL SERVICE	260	584	292	0	1,136	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,040,495	268,173	133,834	149,477	5,591,979	30.00
31.00	03100	INTENSIVE CARE UNIT	1,397,023	37,189	18,560	45,082	1,497,854	31.00
40.00	04000	SUBPROVIDER - IPF	1,652,486	28,512	14,229	44,169	1,739,396	40.00
43.00	04300	NURSERY	10	0	0	0	10	43.00
44.00	04400	SKILLED NURSING FACILITY	1,014,018	66,204	33,040	21,658	1,134,920	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,609,732	172,733	86,204	71,482	4,940,151	50.00
51.00	05100	RECOVERY ROOM	1,187,643	0	0	39,066	1,226,709	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	121,628	2,832	1,414	1,922	127,796	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,980,749	112,006	55,897	46,260	2,194,912	54.00
57.00	05700	CT SCAN	482,610	0	0	11,115	493,725	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	918,513	0	0	11,808	930,321	58.00
60.00	06000	LABORATORY	2,328,209	47,604	23,757	47,253	2,446,823	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	406,416	0	0	902	407,318	63.00
64.00	06400	INTRAVENOUS THERAPY	1,174,231	0	0	31,871	1,206,102	64.00
65.00	06500	RESPIRATORY THERAPY	1,243,342	17,358	8,663	32,352	1,301,715	65.00
66.00	06600	PHYSICAL THERAPY	1,282,355	3,360	1,677	18,456	1,305,848	66.00
67.00	06700	OCCUPATIONAL THERAPY	273,383	0	0	3,010	276,393	67.00
68.00	06800	SPEECH PATHOLOGY	103,066	0	0	707	103,773	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	227,072	35,943	17,938	6,381	287,334	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,812,987	46,091	23,002	0	8,882,080	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,818,097	0	0	0	4,818,097	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,700,913	0	0	0	2,700,913	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	72,515	0	0	2,268	74,783	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	365,837	0	0	3,079	368,916	76.02
76.03	03140	CARDIOLOGY	1,053,067	0	0	23,347	1,076,414	76.03
76.97	07697	CARDIAC REHABILITATION	387,825	0	0	10,444	398,269	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,145,778	39,380	19,653	46,666	2,251,477	90.00
91.00	09100	EMERGENCY	1,625,046	47,068	23,490	49,592	1,745,196	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	78,176,455	1,577,499	787,265	939,706	77,987,628	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,531	9,248	0	27,779	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	1,450	0	0	0	1,450	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	412,103	0	0	9,264	421,367	194.04
194.05	07955	FOUNDATION	0	11,559	5,768	0	17,327	194.05
194.06	07956	DAYCARE CENTER	641,989	37,422	18,676	17,972	716,059	194.06
194.07	07957	UN-USED SQR FT - POB	0	2,097	1,046	0	3,143	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	1,062,638	0	0	26,046	1,088,684	194.09
194.10	07960	ARC INGALLS	1,212,085	0	0	31,198	1,243,283	194.10
200.00		Cross Foot Adjustments					0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/18/2016 10:54 am

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	81,506,720	1,647,108	822,003	1,024,186	81,506,720	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/18/2016 10:54 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,509,230					5.00
6.00	00600	MAINTENANCE & REPAIRS	410,138	2,155,428				6.00
7.00	00700	OPERATION OF PLANT	979,582	36,078	5,184,146			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	85,526	29,233	71,507	550,213		8.00
9.00	00900	HOUSEKEEPING	266,120	49,532	121,161	0	1,569,252	9.00
10.00	01000	DIETARY	114,069	38,805	94,921	0	29,842	10.00
11.00	01100	CAFETERIA	160,832	110,209	269,582	0	84,753	11.00
13.00	01300	NURSING ADMINISTRATION	334,306	17,762	43,447	0	13,659	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	202,452	0	0	0	0	14.00
15.00	01500	PHARMACY	389,438	25,040	61,249	0	19,256	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	100,286	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	267	1,086	2,657	0	835	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,314,098	498,456	1,219,280	284,679	383,325	30.00
31.00	03100	INTENSIVE CARE UNIT	351,991	69,125	169,086	33,848	53,158	31.00
40.00	04000	SUBPROVIDER - IPF	408,753	52,996	129,634	96,867	40,755	40.00
43.00	04300	NURSERY	2	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	266,703	123,055	301,006	134,819	94,632	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,160,921	321,062	785,351	0	246,903	50.00
51.00	05100	RECOVERY ROOM	288,273	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	30,032	5,265	12,878	0	4,049	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	515,798	208,187	509,246	0	160,100	54.00
57.00	05700	CT SCAN	116,024	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	218,623	0	0	0	0	58.00
60.00	06000	LABORATORY	574,996	88,482	216,435	0	68,044	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	95,719	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	283,430	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	305,899	32,264	78,922	0	24,812	65.00
66.00	06600	PHYSICAL THERAPY	306,870	6,245	15,275	0	4,802	66.00
67.00	06700	OCCUPATIONAL THERAPY	64,952	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	24,386	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	67,523	66,808	163,418	0	51,376	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,087,280	85,671	209,559	0	65,883	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,132,238	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	634,706	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	17,574	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	86,694	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	252,954	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	93,592	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	529,090	73,197	179,046	0	56,290	90.00
91.00	09100	EMERGENCY	410,116	87,486	214,001	0	67,279	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,682,253	2,026,044	4,867,661	550,213	1,469,753	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,528	34,445	84,255	0	26,489	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	341	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	99,020	0	0	0	0	194.04
194.05	07955	FOUNDATION	4,072	21,484	52,552	0	16,522	194.05
194.06	07956	DAYCARE CENTER	168,272	69,558	170,145	0	53,491	194.06
194.07	07957	UN-USED SQR FT - POB	739	3,897	9,533	0	2,997	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	255,837	0	0	0	0	194.09
194.10	07960	ARC INGALLS	292,168	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	15,509,230	2,155,428	5,184,146	550,213	1,569,252	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/18/2016 10:54 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	763,042					10.00
11.00	01100	CAFETERIA	0	1,309,778				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,831,772			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,326	0	1,084,287		14.00
15.00	01500	PHARMACY	0	84,979	0	0	2,237,168	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	394,796	270,092	556,953	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	46,940	81,458	167,969	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	134,337	79,808	164,567	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	186,969	39,133	80,694	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	129,161	266,334	0	0	50.00
51.00	05100	RECOVERY ROOM	0	70,588	145,554	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,473	7,162	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	83,587	172,359	0	0	54.00
57.00	05700	CT SCAN	0	20,084	41,413	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	21,335	43,993	0	0	58.00
60.00	06000	LABORATORY	0	85,381	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	57,588	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	58,456	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,530	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	689,584	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	394,703	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,237,168	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	4,098	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	5,563	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	42,186	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	18,871	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	89,608	184,774	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	763,042	1,277,305	1,831,772	1,084,287	2,237,168	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	32,473	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	763,042	1,309,778	1,831,772	1,084,287	2,237,168	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/18/2016 10:54 am

		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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	527,042					16.00
17.00	01700	SOCIAL SERVICE	0	5,981				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,374	3,094	10,559,126	0	10,559,126	30.00
31.00	03100	INTENSIVE CARE UNIT	9,889	368	2,481,686	0	2,481,686	31.00
40.00	04000	SUBPROVIDER - IPF	13,108	1,053	2,861,274	0	2,861,274	40.00
43.00	04300	NURSERY	1	0	13	0	13	43.00
44.00	04400	SKILLED NURSING FACILITY	7,116	1,466	2,370,513	0	2,370,513	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	94,028	0	7,943,911	0	7,943,911	50.00
51.00	05100	RECOVERY ROOM	17,912	0	1,749,036	0	1,749,036	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	24,189	0	214,844	0	214,844	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,038	0	3,871,227	0	3,871,227	54.00
57.00	05700	CT SCAN	32,596	0	703,842	0	703,842	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	21,414	0	1,235,686	0	1,235,686	58.00
60.00	06000	LABORATORY	35,328	0	3,515,489	0	3,515,489	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	3,085	0	506,122	0	506,122	63.00
64.00	06400	INTRAVENOUS THERAPY	12,584	0	1,559,704	0	1,559,704	64.00
65.00	06500	RESPIRATORY THERAPY	9,227	0	1,811,295	0	1,811,295	65.00
66.00	06600	PHYSICAL THERAPY	9,536	0	1,648,576	0	1,648,576	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,006	0	343,351	0	343,351	67.00
68.00	06800	SPEECH PATHOLOGY	793	0	128,952	0	128,952	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,297	0	649,286	0	649,286	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	33,118	0	12,053,175	0	12,053,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,993	0	6,376,031	0	6,376,031	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,380	0	5,608,167	0	5,608,167	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	1,313	0	97,768	0	97,768	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	7,079	0	468,252	0	468,252	76.02
76.03	03140	CARDIOLOGY	16,420	0	1,387,974	0	1,387,974	76.03
76.97	07697	CARDIAC REHABILITATION	1,469	0	512,201	0	512,201	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,692	0	3,098,792	0	3,098,792	90.00
91.00	09100	EMERGENCY	28,057	0	2,826,517	0	2,826,517	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	527,042	5,981	76,582,810	0	76,582,810	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	179,496	0	179,496	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	1,791	0	1,791	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	520,387	0	520,387	194.04
194.05	07955	FOUNDATION	0	0	111,957	0	111,957	194.05
194.06	07956	DAYCARE CENTER	0	0	1,209,998	0	1,209,998	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	20,309	0	20,309	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	1,344,521	0	1,344,521	194.09
194.10	07960	ARC INGALLS	0	0	1,535,451	0	1,535,451	194.10
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)	527,042	5,981	81,506,720	0	81,506,720	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/18/2016 10:54 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,085	48,609	24,259	75,953	75,953	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,460	166,235	82,961	259,656	5,191	5.00
6.00	00600	MAINTENANCE & REPAIRS	193,568	272,634	136,058	602,260	0	6.00
7.00	00700	OPERATION OF PLANT	121,509	19,410	9,687	150,606	3,081	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,728	7,849	23,577	75	8.00
9.00	00900	HOUSEKEEPING	8,678	26,649	13,299	48,626	2,027	9.00
10.00	01000	DIETARY	79,776	20,877	10,419	111,072	747	10.00
11.00	01100	CAFETERIA	0	59,293	29,591	88,884	971	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,556	4,769	14,325	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	159,760	0	0	159,760	834	14.00
15.00	01500	PHARMACY	94,990	13,471	6,723	115,184	3,488	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	584	292	876	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	98,833	268,173	133,834	500,840	11,084	30.00
31.00	03100	INTENSIVE CARE UNIT	60,152	37,189	18,560	115,901	3,343	31.00
40.00	04000	SUBPROVIDER - IPF	81,374	28,512	14,229	124,115	3,276	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,881	66,204	33,040	106,125	1,606	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	991,244	172,733	86,204	1,250,181	5,301	50.00
51.00	05100	RECOVERY ROOM	6,235	0	0	6,235	2,897	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	40,672	2,832	1,414	44,918	143	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	246,218	112,006	55,897	414,121	3,431	54.00
57.00	05700	CT SCAN	134,040	0	0	134,040	824	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	495,676	0	0	495,676	876	58.00
60.00	06000	LABORATORY	118,742	47,604	23,757	190,103	3,504	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	17,660	0	0	17,660	67	63.00
64.00	06400	INTRAVENOUS THERAPY	38,311	0	0	38,311	2,364	64.00
65.00	06500	RESPIRATORY THERAPY	91,650	17,358	8,663	117,671	2,399	65.00
66.00	06600	PHYSICAL THERAPY	7,416	3,360	1,677	12,453	1,369	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,386	0	0	1,386	223	67.00
68.00	06800	SPEECH PATHOLOGY	467	0	0	467	52	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,008	35,943	17,938	63,889	473	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	46,091	23,002	69,093	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	4,691	0	0	4,691	168	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	268,835	0	0	268,835	228	76.02
76.03	03140	CARDIOLOGY	287,116	0	0	287,116	1,731	76.03
76.97	07697	CARDIAC REHABILITATION	97,689	0	0	97,689	775	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	141,917	39,380	19,653	200,950	3,461	90.00
91.00	09100	EMERGENCY	99,991	47,068	23,490	170,549	3,678	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,019,030	1,577,499	787,265	6,383,794	69,687	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,531	9,248	27,779	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	486	0	0	486	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	687	194.04
194.05	07955	FOUNDATION	0	11,559	5,768	17,327	0	194.05
194.06	07956	DAYCARE CENTER	2,158	37,422	18,676	58,256	1,333	194.06
194.07	07957	UN-USED SQR FT - POB	0	2,097	1,046	3,143	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	1,932	194.09
194.10	07960	ARC INGALLS	1,392	0	0	1,392	2,314	194.10
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/18/2016 10:54 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118-201)	4,023,066	1,647,108	822,003	6,492,177	75,953	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/18/2016 10:54 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	264,847					5.00
6.00	00600	MAINTENANCE & REPAIRS	7,004	609,264				6.00
7.00	00700	OPERATION OF PLANT	16,728	10,198	180,613			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,461	8,263	2,491	35,867		8.00
9.00	00900	HOUSEKEEPING	4,544	14,001	4,221	0	73,419	9.00
10.00	01000	DIETARY	1,948	10,969	3,307	0	1,396	10.00
11.00	01100	CAFETERIA	2,747	31,152	9,392	0	3,965	11.00
13.00	01300	NURSING ADMINISTRATION	5,709	5,021	1,514	0	639	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,457	0	0	0	0	14.00
15.00	01500	PHARMACY	6,650	7,078	2,134	0	901	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,713	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	5	307	93	0	39	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,441	140,897	42,479	18,557	17,934	30.00
31.00	03100	INTENSIVE CARE UNIT	6,011	19,539	5,891	2,206	2,487	31.00
40.00	04000	SUBPROVIDER - IPF	6,980	14,980	4,516	6,315	1,907	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,554	34,783	10,487	8,789	4,427	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,825	90,753	27,361	0	11,552	50.00
51.00	05100	RECOVERY ROOM	4,923	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	513	1,488	449	0	189	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,808	58,847	17,742	0	7,490	54.00
57.00	05700	CT SCAN	1,981	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,733	0	0	0	0	58.00
60.00	06000	LABORATORY	9,819	25,011	7,540	0	3,184	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	1,635	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	4,840	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,224	9,120	2,750	0	1,161	65.00
66.00	06600	PHYSICAL THERAPY	5,240	1,765	532	0	225	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,109	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	416	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,153	18,884	5,693	0	2,404	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,643	24,216	7,301	0	3,082	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,335	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,839	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	300	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	1,480	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	4,320	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1,598	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,035	20,690	6,238	0	2,634	90.00
91.00	09100	EMERGENCY	7,003	24,729	7,456	0	3,148	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	250,724	572,691	169,587	35,867	68,764	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	111	9,736	2,935	0	1,239	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	6	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	1,691	0	0	0	0	194.04
194.05	07955	FOUNDATION	70	6,073	1,831	0	773	194.05
194.06	07956	DAYCARE CENTER	2,874	19,662	5,928	0	2,503	194.06
194.07	07957	UN-USED SQR FT - POB	13	1,102	332	0	140	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	4,369	0	0	0	0	194.09
194.10	07960	ARC INGALLS	4,989	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	264,847	609,264	180,613	35,867	73,419	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/18/2016 10:54 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	129,439					10.00
11.00	01100	CAFETERIA	0	137,111				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	27,208			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,128	0	166,179		14.00
15.00	01500	PHARMACY	0	8,896	0	0	144,331	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	66,971	28,276	8,276	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,963	8,527	2,495	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	22,788	8,355	2,444	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	31,717	4,097	1,198	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,521	3,955	0	0	50.00
51.00	05100	RECOVERY ROOM	0	7,389	2,162	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	364	106	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,750	2,560	0	0	54.00
57.00	05700	CT SCAN	0	2,102	615	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,233	653	0	0	58.00
60.00	06000	LABORATORY	0	8,938	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	6,028	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,119	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,207	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	105,688	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	60,491	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	144,331	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	429	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	582	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	4,416	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	1,975	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	9,380	2,744	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	129,439	133,712	27,208	166,179	144,331	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	3,399	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	129,439	137,111	27,208	166,179	144,331	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/18/2016 10:54 am

		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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	1,713					16.00
17.00	01700	SOCIAL SERVICE	0	1,320				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	123	684	858,562	0	858,562	30.00
31.00	03100	INTENSIVE CARE UNIT	29	81	174,473	0	174,473	31.00
40.00	04000	SUBPROVIDER - IPF	38	232	195,946	0	195,946	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	21	323	208,127	0	208,127	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	455	0	1,422,904	0	1,422,904	50.00
51.00	05100	RECOVERY ROOM	52	0	23,658	0	23,658	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	70	0	48,240	0	48,240	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	78	0	521,827	0	521,827	54.00
57.00	05700	CT SCAN	95	0	139,657	0	139,657	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	62	0	503,233	0	503,233	58.00
60.00	06000	LABORATORY	102	0	248,201	0	248,201	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	9	0	19,371	0	19,371	63.00
64.00	06400	INTRAVENOUS THERAPY	37	0	51,580	0	51,580	64.00
65.00	06500	RESPIRATORY THERAPY	27	0	144,471	0	144,471	65.00
66.00	06600	PHYSICAL THERAPY	28	0	21,612	0	21,612	66.00
67.00	06700	OCCUPATIONAL THERAPY	6	0	2,724	0	2,724	67.00
68.00	06800	SPEECH PATHOLOGY	2	0	937	0	937	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4	0	93,707	0	93,707	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	96	0	245,119	0	245,119	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	90	0	79,916	0	79,916	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	103	0	155,273	0	155,273	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	4	0	5,592	0	5,592	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	21	0	271,146	0	271,146	76.02
76.03	03140	CARDIOLOGY	48	0	297,631	0	297,631	76.03
76.97	07697	CARDIAC REHABILITATION	4	0	102,041	0	102,041	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	28	0	243,036	0	243,036	90.00
91.00	09100	EMERGENCY	81	0	228,768	0	228,768	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,713	1,320	6,307,752	0	6,307,752	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	41,800	0	41,800	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	492	0	492	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	2,378	0	2,378	194.04
194.05	07955	FOUNDATION	0	0	26,074	0	26,074	194.05
194.06	07956	DAYCARE CENTER	0	0	93,955	0	93,955	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	4,730	0	4,730	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	6,301	0	6,301	194.09
194.10	07960	ARC INGALLS	0	0	8,695	0	8,695	194.10
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)	1,713	1,320	6,492,177	0	6,492,177	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/18/2016 10:54 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	402,992					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		402,992				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,893	11,893	27,155,269			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	40,672	40,672	1,855,837	-15,509,230	65,997,490	5.00
6.00	00600	MAINTENANCE & REPAIRS	66,704	66,704	0	0	1,745,290	6.00
7.00	00700	OPERATION OF PLANT	4,749	4,749	1,101,480	0	4,168,486	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,848	3,848	26,934	0	363,947	8.00
9.00	00900	HOUSEKEEPING	6,520	6,520	724,843	0	1,132,439	9.00
10.00	01000	DIETARY	5,108	5,108	267,163	0	485,405	10.00
11.00	01100	CAFETERIA	14,507	14,507	347,127	0	684,402	11.00
13.00	01300	NURSING ADMINISTRATION	2,338	2,338	0	0	1,422,598	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	298,258	0	861,509	14.00
15.00	01500	PHARMACY	3,296	3,296	1,246,962	0	1,657,206	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	426,756	16.00
17.00	01700	SOCIAL SERVICE	143	143	0	0	1,136	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,613	65,613	3,963,346	0	5,591,979	30.00
31.00	03100	INTENSIVE CARE UNIT	9,099	9,099	1,195,298	0	1,497,854	31.00
40.00	04000	SUBPROVIDER - IPF	6,976	6,976	1,171,087	0	1,739,396	40.00
43.00	04300	NURSERY	0	0	0	0	10	43.00
44.00	04400	SKILLED NURSING FACILITY	16,198	16,198	574,231	0	1,134,920	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,262	42,262	1,895,276	0	4,940,151	50.00
51.00	05100	RECOVERY ROOM	0	0	1,035,786	0	1,226,709	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	693	693	50,966	0	127,796	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,404	27,404	1,226,533	0	2,194,912	54.00
57.00	05700	CT SCAN	0	0	294,705	0	493,725	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	313,065	0	930,321	58.00
60.00	06000	LABORATORY	11,647	11,647	1,252,861	0	2,446,823	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	23,908	0	407,318	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	845,031	0	1,206,102	64.00
65.00	06500	RESPIRATORY THERAPY	4,247	4,247	857,770	0	1,301,715	65.00
66.00	06600	PHYSICAL THERAPY	822	822	489,335	0	1,305,848	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	79,812	0	276,393	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	18,744	0	103,773	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,794	8,794	169,185	0	287,334	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,277	11,277	0	0	8,882,080	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,818,097	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,700,913	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	60,131	0	74,783	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	81,626	0	368,916	76.02
76.03	03140	CARDIOLOGY	0	0	619,027	0	1,076,414	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	276,905	0	398,269	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,635	9,635	1,237,293	0	2,251,477	90.00
91.00	09100	EMERGENCY	11,516	11,516	1,314,882	0	1,745,196	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	385,961	385,961	24,915,407	-15,509,230	62,478,398	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	0	27,779	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	1,450	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	245,614	0	421,367	194.04
194.05	07955	FOUNDATION	2,828	2,828	0	0	17,327	194.05
194.06	07956	DAYCARE CENTER	9,156	9,156	476,504	0	716,059	194.06
194.07	07957	UN-USED SQR FT - POB	513	513	0	0	3,143	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	690,573	0	1,088,684	194.09
194.10	07960	ARC INGALLS	0	0	827,171	0	1,243,283	194.10
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/18/2016 10:54 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,647,108	822,003	1,024,186		15,509,230	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.087198	2.039750	0.037716		0.234997	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			75,953		264,847	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002797		0.004013	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/18/2016 10:54 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	283,723					6.00
7.00	00700	OPERATION OF PLANT	4,749	278,974				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,848	3,848	26,009			8.00
9.00	00900	HOUSEKEEPING	6,520	6,520	0	268,606		9.00
10.00	01000	DIETARY	5,108	5,108	0	5,108	26,009	10.00
11.00	01100	CAFETERIA	14,507	14,507	0	14,507	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,338	2,338	0	2,338	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,296	3,296	0	3,296	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	143	143	0	143	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,613	65,613	13,457	65,613	13,457	30.00
31.00	03100	INTENSIVE CARE UNIT	9,099	9,099	1,600	9,099	1,600	31.00
40.00	04000	SUBPROVIDER - IPF	6,976	6,976	4,579	6,976	4,579	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	16,198	16,198	6,373	16,198	6,373	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,262	42,262	0	42,262	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	693	693	0	693	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,404	27,404	0	27,404	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	11,647	11,647	0	11,647	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,247	4,247	0	4,247	0	65.00
66.00	06600	PHYSICAL THERAPY	822	822	0	822	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
70.00	07000	ELECTROENCEPHALOGRAPHY	8,794	8,794	0	8,794	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,277	11,277	0	11,277	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,635	9,635	0	9,635	0	90.00
91.00	09100	EMERGENCY	11,516	11,516	0	11,516	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	266,692	261,943	26,009	251,575	26,009	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	4,534	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	2,828	2,828	0	2,828	0	194.05
194.06	07956	DAYCARE CENTER	9,156	9,156	0	9,156	0	194.06
194.07	07957	UN-USED SQR FT - POB	513	513	0	513	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,155,428	5,184,146	550,213	1,569,252	763,042	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/18/2016 10:54 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	7.596945	18.582900	21.154716	5.842208	29.337614	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	609,264	180,613	35,867	73,419	129,439	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.147390	0.647419	1.379023	0.273333	4.976700	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/18/2016 10:54 am

		Cost Center Description	CAFETERIA (GROSS SALARIE)	NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	19,219,435					11.00
13.00	01300	NURSING ADMINISTRATION	0	13,035,175				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	298,258	0	13,235,727			14.00
15.00	01500	PHARMACY	1,246,962	0	0	2,700,914		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	382,172,449	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,963,346	3,963,346	0	0	30,728,096	30.00
31.00	03100	INTENSIVE CARE UNIT	1,195,298	1,195,298	0	0	7,171,198	31.00
40.00	04000	SUBPROVIDER - IPF	1,171,087	1,171,087	0	0	9,505,580	40.00
43.00	04300	NURSERY	0	0	0	0	769	43.00
44.00	04400	SKILLED NURSING FACILITY	574,231	574,231	0	0	5,160,605	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,895,276	1,895,276	0	0	68,165,342	50.00
51.00	05100	RECOVERY ROOM	1,035,786	1,035,786	0	0	12,989,074	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	50,966	50,966	0	0	17,540,714	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,226,533	1,226,533	0	0	19,607,138	54.00
57.00	05700	CT SCAN	294,705	294,705	0	0	23,637,384	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	313,065	313,065	0	0	15,528,460	58.00
60.00	06000	LABORATORY	1,252,861	0	0	0	25,618,895	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	2,237,474	63.00
64.00	06400	INTRAVENOUS THERAPY	845,031	0	0	0	9,125,799	64.00
65.00	06500	RESPIRATORY THERAPY	857,770	0	0	0	6,690,786	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	6,915,278	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,454,811	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	575,273	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	169,185	0	0	0	940,699	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	8,417,631	0	24,015,997	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,818,096	0	22,474,790	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,700,914	25,656,251	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	60,131	0	0	0	951,847	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	81,626	0	0	0	5,133,101	76.02
76.03	03140	CARDIOLOGY	619,027	0	0	0	11,907,099	76.03
76.97	07697	CARDIAC REHABILITATION	276,905	0	0	0	1,065,387	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	7,028,550	90.00
91.00	09100	EMERGENCY	1,314,882	1,314,882	0	0	20,346,052	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,742,931	13,035,175	13,235,727	2,700,914	382,172,449	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	476,504	0	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/18/2016 10:54 am

		Cost Center Description	CAFETERIA (GROSS SALARIE)	NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	1,309,778	1,831,772	1,084,287	2,237,168	527,042	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.068149	0.140525	0.081921	0.828300	0.001379	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	137,111	27,208	166,179	144,331	1,713	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.007134	0.002087	0.012555	0.053438	0.000004	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/18/2016 10:54 am

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
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	26,009		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	13,457		30.00
31.00	03100	INTENSIVE CARE UNIT	1,600		31.00
40.00	04000	SUBPROVIDER - IPF	4,579		40.00
43.00	04300	NURSERY	0		43.00
44.00	04400	SKILLED NURSING FACILITY	6,373		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
60.00	06000	LABORATORY	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
76.00	03950	ANCILLARY	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0		76.02
76.03	03140	CARDIOLOGY	0		76.03
76.97	07697	CARDIAC REHABILITATION	0		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,009		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0		194.00
194.01	07951	MEALS ON WHEELS	0		194.01
194.02	07952	MARKETING	0		194.02
194.03	07953	GUEST MEALS	0		194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0		194.04
194.05	07955	FOUNDATION	0		194.05
194.06	07956	DAYCARE CENTER	0		194.06
194.07	07957	UN-USED SQR FT - POB	0		194.07
194.08	07958	SENIOR SERVICES	0		194.08
194.09	07959	ARC BROMENN	0		194.09
194.10	07960	ARC INGALLS	0		194.10
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)	5,981		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/18/2016 10:54 am

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)		
			17.00		
203.00		Unit cost multiplier (Wkst. B, Part I)	0.229959		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,320		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.050752		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/18/2016 10:54 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,559,126		10,559,126	0	10,559,126	30.00
31.00	03100	INTENSIVE CARE UNIT	2,481,686		2,481,686	0	2,481,686	31.00
40.00	04000	SUBPROVIDER - IPF	2,861,274		2,861,274	0	2,861,274	40.00
43.00	04300	NURSERY	13		13	0	13	43.00
44.00	04400	SKILLED NURSING FACILITY	2,370,513		2,370,513	0	2,370,513	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,943,911		7,943,911	0	7,943,911	50.00
51.00	05100	RECOVERY ROOM	1,749,036		1,749,036	0	1,749,036	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	214,844		214,844	9,086	223,930	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,871,227		3,871,227	0	3,871,227	54.00
57.00	05700	CT SCAN	703,842		703,842	0	703,842	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,235,686		1,235,686	0	1,235,686	58.00
60.00	06000	LABORATORY	3,515,489		3,515,489	0	3,515,489	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	506,122		506,122	0	506,122	63.00
64.00	06400	INTRAVENOUS THERAPY	1,559,704		1,559,704	0	1,559,704	64.00
65.00	06500	RESPIRATORY THERAPY	1,811,295	0	1,811,295	0	1,811,295	65.00
66.00	06600	PHYSICAL THERAPY	1,648,576	0	1,648,576	0	1,648,576	66.00
67.00	06700	OCCUPATIONAL THERAPY	343,351	0	343,351	0	343,351	67.00
68.00	06800	SPEECH PATHOLOGY	128,952	0	128,952	0	128,952	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	649,286		649,286	0	649,286	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,053,175		12,053,175	0	12,053,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,376,031		6,376,031	0	6,376,031	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,608,167		5,608,167	0	5,608,167	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	97,768		97,768	0	97,768	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	468,252		468,252	0	468,252	76.02
76.03	03140	CARDIOLOGY	1,387,974		1,387,974	0	1,387,974	76.03
76.97	07697	CARDIAC REHABILITATION	512,201		512,201	0	512,201	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,098,792		3,098,792	0	3,098,792	90.00
91.00	09100	EMERGENCY	2,826,517		2,826,517	0	2,826,517	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,564,678		1,564,678		1,564,678	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	78,147,488	0	78,147,488	9,086	78,156,574	200.00
201.00		Less Observation Beds	1,564,678		1,564,678		1,564,678	201.00
202.00		Total (see instructions)	76,582,810	0	76,582,810	9,086	76,591,896	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/18/2016 10:54 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,366,151		27,366,151			30.00
31.00	03100	INTENSIVE CARE UNIT	7,171,198		7,171,198			31.00
40.00	04000	SUBPROVIDER - IPF	9,505,580		9,505,580			40.00
43.00	04300	NURSERY	769		769			43.00
44.00	04400	SKILLED NURSING FACILITY	5,160,605		5,160,605			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,186,343	48,978,999	68,165,342	0.116539	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,436,058	8,553,016	12,989,074	0.134654	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,240,005	13,300,709	17,540,714	0.012248	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,758,382	14,848,756	19,607,138	0.197440	0.000000	54.00
57.00	05700	CT SCAN	6,310,632	17,326,752	23,637,384	0.029777	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,149,808	13,378,652	15,528,460	0.079576	0.000000	58.00
60.00	06000	LABORATORY	10,132,408	15,486,487	25,618,895	0.137223	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	1,251,144	986,330	2,237,474	0.226202	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	2,002,255	7,123,544	9,125,799	0.170912	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,508,663	2,182,123	6,690,786	0.270715	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,693,810	221,468	6,915,278	0.238396	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,413,776	41,035	1,454,811	0.236011	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	550,941	24,332	575,273	0.224158	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	106,805	833,894	940,699	0.690217	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,885,882	12,130,115	24,015,997	0.501881	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,950,681	10,524,109	22,474,790	0.283697	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,262,952	11,393,299	25,656,251	0.218589	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	390,963	560,884	951,847	0.102714	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	1,582,772	3,550,329	5,133,101	0.091222	0.000000	76.02
76.03	03140	CARDIOLOGY	4,588,631	7,318,468	11,907,099	0.116567	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	1,065,387	1,065,387	0.480765	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	303,187	6,725,363	7,028,550	0.440886	0.000000	90.00
91.00	09100	EMERGENCY	4,104,087	16,241,965	20,346,052	0.138922	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	352,112	3,009,833	3,361,945	0.465409	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	166,366,600	215,805,849	382,172,449			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	166,366,600	215,805,849	382,172,449			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/18/2016 10:54 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.116539	50.00
51.00	05100	RECOVERY ROOM	0.134654	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.012766	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197440	54.00
57.00	05700	CT SCAN	0.029777	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.079576	58.00
60.00	06000	LABORATORY	0.137223	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.226202	63.00
64.00	06400	INTRAVENOUS THERAPY	0.170912	64.00
65.00	06500	RESPIRATORY THERAPY	0.270715	65.00
66.00	06600	PHYSICAL THERAPY	0.238396	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236011	67.00
68.00	06800	SPEECH PATHOLOGY	0.224158	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.690217	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.501881	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.283697	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218589	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03950	ANCILLARY	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.102714	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.091222	76.02
76.03	03140	CARDIOLOGY	0.116567	76.03
76.97	07697	CARDIAC REHABILITATION	0.480765	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.440886	90.00
91.00	09100	EMERGENCY	0.138922	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.465409	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
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: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/18/2016 10:54 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,559,126		10,559,126	0	10,559,126	30.00
31.00	03100	INTENSIVE CARE UNIT	2,481,686		2,481,686	0	2,481,686	31.00
40.00	04000	SUBPROVIDER - IPF	2,861,274		2,861,274	0	2,861,274	40.00
43.00	04300	NURSERY	13		13	0	13	43.00
44.00	04400	SKILLED NURSING FACILITY	2,370,513		2,370,513	0	2,370,513	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,943,911		7,943,911	0	7,943,911	50.00
51.00	05100	RECOVERY ROOM	1,749,036		1,749,036	0	1,749,036	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	214,844		214,844	9,086	223,930	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,871,227		3,871,227	0	3,871,227	54.00
57.00	05700	CT SCAN	703,842		703,842	0	703,842	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,235,686		1,235,686	0	1,235,686	58.00
60.00	06000	LABORATORY	3,515,489		3,515,489	0	3,515,489	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	506,122		506,122	0	506,122	63.00
64.00	06400	INTRAVENOUS THERAPY	1,559,704		1,559,704	0	1,559,704	64.00
65.00	06500	RESPIRATORY THERAPY	1,811,295	0	1,811,295	0	1,811,295	65.00
66.00	06600	PHYSICAL THERAPY	1,648,576	0	1,648,576	0	1,648,576	66.00
67.00	06700	OCCUPATIONAL THERAPY	343,351	0	343,351	0	343,351	67.00
68.00	06800	SPEECH PATHOLOGY	128,952	0	128,952	0	128,952	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	649,286		649,286	0	649,286	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,053,175		12,053,175	0	12,053,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,376,031		6,376,031	0	6,376,031	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,608,167		5,608,167	0	5,608,167	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	97,768		97,768	0	97,768	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	468,252		468,252	0	468,252	76.02
76.03	03140	CARDIOLOGY	1,387,974		1,387,974	0	1,387,974	76.03
76.97	07697	CARDIAC REHABILITATION	512,201		512,201	0	512,201	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,098,792		3,098,792	0	3,098,792	90.00
91.00	09100	EMERGENCY	2,826,517		2,826,517	0	2,826,517	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,564,678		1,564,678		1,564,678	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	78,147,488	0	78,147,488	9,086	78,156,574	200.00
201.00		Less Observation Beds	1,564,678		1,564,678		1,564,678	201.00
202.00		Total (see instructions)	76,582,810	0	76,582,810	9,086	76,591,896	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,366,151		27,366,151			30.00
31.00	03100	INTENSIVE CARE UNIT	7,171,198		7,171,198			31.00
40.00	04000	SUBPROVIDER - IPF	9,505,580		9,505,580			40.00
43.00	04300	NURSERY	769		769			43.00
44.00	04400	SKILLED NURSING FACILITY	5,160,605		5,160,605			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,186,343	48,978,999	68,165,342	0.116539	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,436,058	8,553,016	12,989,074	0.134654	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,240,005	13,300,709	17,540,714	0.012248	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,758,382	14,848,756	19,607,138	0.197440	0.000000	54.00
57.00	05700	CT SCAN	6,310,632	17,326,752	23,637,384	0.029777	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,149,808	13,378,652	15,528,460	0.079576	0.000000	58.00
60.00	06000	LABORATORY	10,132,408	15,486,487	25,618,895	0.137223	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	1,251,144	986,330	2,237,474	0.226202	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	2,002,255	7,123,544	9,125,799	0.170912	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,508,663	2,182,123	6,690,786	0.270715	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,693,810	221,468	6,915,278	0.238396	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,413,776	41,035	1,454,811	0.236011	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	550,941	24,332	575,273	0.224158	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	106,805	833,894	940,699	0.690217	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,885,882	12,130,115	24,015,997	0.501881	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,950,681	10,524,109	22,474,790	0.283697	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,262,952	11,393,299	25,656,251	0.218589	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	390,963	560,884	951,847	0.102714	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	1,582,772	3,550,329	5,133,101	0.091222	0.000000	76.02
76.03	03140	CARDIOLOGY	4,588,631	7,318,468	11,907,099	0.116567	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	1,065,387	1,065,387	0.480765	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	303,187	6,725,363	7,028,550	0.440886	0.000000	90.00
91.00	09100	EMERGENCY	4,104,087	16,241,965	20,346,052	0.138922	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	352,112	3,009,833	3,361,945	0.465409	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	166,366,600	215,805,849	382,172,449			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	166,366,600	215,805,849	382,172,449			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.116539	50.00
51.00	05100	RECOVERY ROOM	0.134654	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.012766	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197440	54.00
57.00	05700	CT SCAN	0.029777	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.079576	58.00
60.00	06000	LABORATORY	0.137223	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.226202	63.00
64.00	06400	INTRAVENOUS THERAPY	0.170912	64.00
65.00	06500	RESPIRATORY THERAPY	0.270715	65.00
66.00	06600	PHYSICAL THERAPY	0.238396	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236011	67.00
68.00	06800	SPEECH PATHOLOGY	0.224158	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.690217	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.501881	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.283697	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218589	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03950	ANCILLARY	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.102714	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.091222	76.02
76.03	03140	CARDIOLOGY	0.116567	76.03
76.97	07697	CARDIAC REHABILITATION	0.480765	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.440886	90.00
91.00	09100	EMERGENCY	0.138922	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.465409	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
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: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,943,911	1,422,904	6,521,007	0	0	50.00
51.00	05100	RECOVERY ROOM	1,749,036	23,658	1,725,378	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	214,844	48,240	166,604	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,871,227	521,827	3,349,400	0	0	54.00
57.00	05700	CT SCAN	703,842	139,657	564,185	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,235,686	503,233	732,453	0	0	58.00
60.00	06000	LABORATORY	3,515,489	248,201	3,267,288	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	506,122	19,371	486,751	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	1,559,704	51,580	1,508,124	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,811,295	144,471	1,666,824	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,648,576	21,612	1,626,964	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	343,351	2,724	340,627	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	128,952	937	128,015	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	649,286	93,707	555,579	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,053,175	245,119	11,808,056	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,376,031	79,916	6,296,115	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,608,167	155,273	5,452,894	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	97,768	5,592	92,176	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	468,252	271,146	197,106	0	0	76.02
76.03	03140	CARDIOLOGY	1,387,974	297,631	1,090,343	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	512,201	102,041	410,160	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,098,792	243,036	2,855,756	0	0	90.00
91.00	09100	EMERGENCY	2,826,517	228,768	2,597,749	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,564,678	127,224	1,437,454	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
200.00		Subtotal (sum of lines 50 thru 199)	59,874,876	4,997,868	54,877,008	0	0	200.00
201.00		Less Observation Beds	1,564,678	127,224	1,437,454	0	0	201.00
202.00		Total (line 200 minus line 201)	58,310,198	4,870,644	53,439,554	0	0	202.00

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

Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | Hospital | PPS

		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	7,943,911	68,165,342	0.116539		50.00
51.00	05100	RECOVERY ROOM	1,749,036	12,989,074	0.134654		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	214,844	17,540,714	0.012248		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,871,227	19,607,138	0.197440		54.00
57.00	05700	CT SCAN	703,842	23,637,384	0.029777		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,235,686	15,528,460	0.079576		58.00
60.00	06000	LABORATORY	3,515,489	25,618,895	0.137223		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	506,122	2,237,474	0.226202		63.00
64.00	06400	INTRAVENOUS THERAPY	1,559,704	9,125,799	0.170912		64.00
65.00	06500	RESPIRATORY THERAPY	1,811,295	6,690,786	0.270715		65.00
66.00	06600	PHYSICAL THERAPY	1,648,576	6,915,278	0.238396		66.00
67.00	06700	OCCUPATIONAL THERAPY	343,351	1,454,811	0.236011		67.00
68.00	06800	SPEECH PATHOLOGY	128,952	575,273	0.224158		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	649,286	940,699	0.690217		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,053,175	24,015,997	0.501881		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,376,031	22,474,790	0.283697		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,608,167	25,656,251	0.218589		73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000		74.00
76.00	03950	ANCILLARY	0	0	0.000000		76.00
76.01	03560	PULMONARY FUNCTION TESTING	97,768	951,847	0.102714		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	468,252	5,133,101	0.091222		76.02
76.03	03140	CARDIOLOGY	1,387,974	11,907,099	0.116567		76.03
76.97	07697	CARDIAC REHABILITATION	512,201	1,065,387	0.480765		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	3,098,792	7,028,550	0.440886		90.00
91.00	09100	EMERGENCY	2,826,517	20,346,052	0.138922		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,564,678	3,361,945	0.465409		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
200.00		Subtotal (sum of lines 50 thru 199)	59,874,876	332,968,146			200.00
201.00		Less Observation Beds	1,564,678	0			201.00
202.00		Total (line 200 minus line 201)	58,310,198	332,968,146			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I Date/Time Prepared: 5/18/2016 10:54 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	858,562	0	858,562	15,798	54.35	30.00
31.00	INTENSIVE CARE UNIT	174,473		174,473	1,600	109.05	31.00
40.00	SUBPROVIDER - IPF	195,946	0	195,946	4,579	42.79	40.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	208,127		208,127	6,373	32.66	44.00
200.00	Total (lines 30-199)	1,437,108		1,437,108	28,350		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	7,286	395,994	30.00
31.00	INTENSIVE CARE UNIT	863	94,110	31.00
40.00	SUBPROVIDER - IPF	3,280	140,351	40.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	3,912	127,766	44.00
200.00	Total (lines 30-199)	15,341	758,221	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/18/2016 10:54 am

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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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,422,904	68,165,342	0.020874	9,052,833	188,969	50.00
51.00	05100	RECOVERY ROOM	23,658	12,989,074	0.001821	1,992,227	3,628	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	48,240	17,540,714	0.002750	1,881,134	5,173	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	521,827	19,607,138	0.026614	2,404,085	63,982	54.00
57.00	05700	CT SCAN	139,657	23,637,384	0.005908	3,031,248	17,909	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	503,233	15,528,460	0.032407	1,129,984	36,619	58.00
60.00	06000	LABORATORY	248,201	25,618,895	0.009688	4,737,863	45,900	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	19,371	2,237,474	0.008658	650,662	5,633	63.00
64.00	06400	INTRAVENOUS THERAPY	51,580	9,125,799	0.005652	997,082	5,636	64.00
65.00	06500	RESPIRATORY THERAPY	144,471	6,690,786	0.021593	1,985,543	42,874	65.00
66.00	06600	PHYSICAL THERAPY	21,612	6,915,278	0.003125	1,227,656	3,836	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,724	1,454,811	0.001872	397,154	743	67.00
68.00	06800	SPEECH PATHOLOGY	937	575,273	0.001629	243,526	397	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	93,707	940,699	0.099614	61,194	6,096	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	245,119	24,015,997	0.010206	6,200,697	63,284	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,916	22,474,790	0.003556	5,909,547	21,014	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	155,273	25,656,251	0.006052	6,484,882	39,247	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	5,592	951,847	0.005875	208,348	1,224	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	271,146	5,133,101	0.052823	873,966	46,166	76.02
76.03	03140	CARDIOLOGY	297,631	11,907,099	0.024996	2,942,156	73,542	76.03
76.97	07697	CARDIAC REHABILITATION	102,041	1,065,387	0.095778	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	243,036	7,028,550	0.034578	183,477	6,344	90.00
91.00	09100	EMERGENCY	228,768	20,346,052	0.011244	2,145,069	24,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	127,224	3,361,945	0.037842	211,670	8,010	92.00
200.00		Total (lines 50-199)	4,997,868	332,968,146		54,952,003	710,345	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/18/2016 10:54 am

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		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,798	0.00	7,286	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,600	0.00	863	0		31.00
40.00	04000	SUBPROVIDER - IPF	4,579	0.00	3,280	0		40.00
43.00	04300	NURSERY	0	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	6,373	0.00	3,912	0		44.00
200.00		Total (lines 30-199)	28,350		15,341	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/18/2016 10:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/18/2016 10:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	68,165,342	0.000000	0.000000	9,052,833	50.00
51.00	05100	RECOVERY ROOM	0	12,989,074	0.000000	0.000000	1,992,227	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	17,540,714	0.000000	0.000000	1,881,134	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,607,138	0.000000	0.000000	2,404,085	54.00
57.00	05700	CT SCAN	0	23,637,384	0.000000	0.000000	3,031,248	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	15,528,460	0.000000	0.000000	1,129,984	58.00
60.00	06000	LABORATORY	0	25,618,895	0.000000	0.000000	4,737,863	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	2,237,474	0.000000	0.000000	650,662	63.00
64.00	06400	INTRAVENOUS THERAPY	0	9,125,799	0.000000	0.000000	997,082	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,690,786	0.000000	0.000000	1,985,543	65.00
66.00	06600	PHYSICAL THERAPY	0	6,915,278	0.000000	0.000000	1,227,656	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,454,811	0.000000	0.000000	397,154	67.00
68.00	06800	SPEECH PATHOLOGY	0	575,273	0.000000	0.000000	243,526	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	940,699	0.000000	0.000000	61,194	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	24,015,997	0.000000	0.000000	6,200,697	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,474,790	0.000000	0.000000	5,909,547	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,656,251	0.000000	0.000000	6,484,882	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	951,847	0.000000	0.000000	208,348	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	5,133,101	0.000000	0.000000	873,966	76.02
76.03	03140	CARDIOLOGY	0	11,907,099	0.000000	0.000000	2,942,156	76.03
76.97	07697	CARDIAC REHABILITATION	0	1,065,387	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,028,550	0.000000	0.000000	183,477	90.00
91.00	09100	EMERGENCY	0	20,346,052	0.000000	0.000000	2,145,069	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,361,945	0.000000	0.000000	211,670	92.00
200.00		Total (lines 50-199)	0	332,968,146			54,952,003	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/18/2016 10:54 am

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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)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	15,991,386	0		50.00
51.00	05100	RECOVERY ROOM	0	2,103,597	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	3,761,095	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,272,783	0		54.00
57.00	05700	CT SCAN	0	5,195,466	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,300,433	0		58.00
60.00	06000	LABORATORY	0	2,476,438	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	388,081	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,932,068	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	730,961	0		65.00
66.00	06600	PHYSICAL THERAPY	0	4,960	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,652	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	214,434	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,622,507	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,809,671	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,185,897	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	ANCILLARY	0	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	183,558	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	982,872	0		76.02
76.03	03140	CARDIOLOGY	0	1,749,866	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	403,503	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	1,064,504	0		90.00
91.00	09100	EMERGENCY	0	3,475,934	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	877,729	0		92.00
200.00		Total (lines 50-199)	0	59,730,395	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/18/2016 10:54 am

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		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.116539	15,991,386	0	0	1,863,620	50.00
51.00	05100	RECOVERY ROOM	0.134654	2,103,597	0	0	283,258	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.012248	3,761,095	0	0	46,066	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197440	4,272,783	0	0	843,618	54.00
57.00	05700	CT SCAN	0.029777	5,195,466	0	0	154,705	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.079576	3,300,433	0	0	262,635	58.00
60.00	06000	LABORATORY	0.137223	2,476,438	0	0	339,824	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.226202	388,081	0	0	87,785	63.00
64.00	06400	INTRAVENOUS THERAPY	0.170912	1,932,068	0	0	330,214	64.00
65.00	06500	RESPIRATORY THERAPY	0.270715	730,961	0	0	197,882	65.00
66.00	06600	PHYSICAL THERAPY	0.238396	4,960	0	0	1,182	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236011	2,652	0	0	626	67.00
68.00	06800	SPEECH PATHOLOGY	0.224158	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.690217	214,434	0	0	148,006	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.501881	3,622,507	0	0	1,818,067	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.283697	3,809,671	201,591	0	1,080,792	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218589	3,185,897	0	66,051	696,402	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.102714	183,558	0	0	18,854	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.091222	982,872	0	0	89,660	76.02
76.03	03140	CARDIOLOGY	0.116567	1,749,866	0	0	203,977	76.03
76.97	07697	CARDIAC REHABILITATION	0.480765	403,503	0	0	193,990	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.440886	1,064,504	0	0	469,325	90.00
91.00	09100	EMERGENCY	0.138922	3,475,934	0	0	482,884	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.465409	877,729	0	0	408,503	92.00
200.00		Subtotal (see instructions)		59,730,395	201,591	66,051	10,021,875	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		59,730,395	201,591	66,051	10,021,875	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/18/2016 10:54 am

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	57,191	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,438		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0		76.02
76.03	03140	CARDIOLOGY	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	57,191	14,438		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	57,191	14,438		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II | Date/Time Prepared: 5/18/2016 10:54 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,422,904	68,165,342	0.020874	5,174	108	50.00
51.00	05100	RECOVERY ROOM	23,658	12,989,074	0.001821	1,260	2	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	48,240	17,540,714	0.002750	2,041	6	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	521,827	19,607,138	0.026614	63,288	1,684	54.00
57.00	05700	CT SCAN	139,657	23,637,384	0.005908	241,080	1,424	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	503,233	15,528,460	0.032407	28,485	923	58.00
60.00	06000	LABORATORY	248,201	25,618,895	0.009688	344,780	3,340	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	19,371	2,237,474	0.008658	5,486	47	63.00
64.00	06400	INTRAVENOUS THERAPY	51,580	9,125,799	0.005652	13,760	78	64.00
65.00	06500	RESPIRATORY THERAPY	144,471	6,690,786	0.021593	90,343	1,951	65.00
66.00	06600	PHYSICAL THERAPY	21,612	6,915,278	0.003125	146,429	458	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,724	1,454,811	0.001872	12,622	24	67.00
68.00	06800	SPEECH PATHOLOGY	937	575,273	0.001629	12,936	21	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	93,707	940,699	0.099614	1,302	130	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	245,119	24,015,997	0.010206	25,038	256	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,916	22,474,790	0.003556	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	155,273	25,656,251	0.006052	193,715	1,172	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	5,592	951,847	0.005875	1,830	11	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	271,146	5,133,101	0.052823	0	0	76.02
76.03	03140	CARDIOLOGY	297,631	11,907,099	0.024996	20,984	525	76.03
76.97	07697	CARDIAC REHABILITATION	102,041	1,065,387	0.095778	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	243,036	7,028,550	0.034578	8,073	279	90.00
91.00	09100	EMERGENCY	228,768	20,346,052	0.011244	158,577	1,783	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,361,945	0.000000	11,760	0	92.00
200.00		Total (lines 50-199)	4,870,644	332,968,146		1,388,963	14,222	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/18/2016 10:54 am

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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/18/2016 10:54 am

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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	68,165,342	0.000000	0.000000	5,174	50.00
51.00	05100	RECOVERY ROOM	0	12,989,074	0.000000	0.000000	1,260	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	17,540,714	0.000000	0.000000	2,041	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,607,138	0.000000	0.000000	63,288	54.00
57.00	05700	CT SCAN	0	23,637,384	0.000000	0.000000	241,080	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	15,528,460	0.000000	0.000000	28,485	58.00
60.00	06000	LABORATORY	0	25,618,895	0.000000	0.000000	344,780	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	2,237,474	0.000000	0.000000	5,486	63.00
64.00	06400	INTRAVENOUS THERAPY	0	9,125,799	0.000000	0.000000	13,760	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,690,786	0.000000	0.000000	90,343	65.00
66.00	06600	PHYSICAL THERAPY	0	6,915,278	0.000000	0.000000	146,429	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,454,811	0.000000	0.000000	12,622	67.00
68.00	06800	SPEECH PATHOLOGY	0	575,273	0.000000	0.000000	12,936	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	940,699	0.000000	0.000000	1,302	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	24,015,997	0.000000	0.000000	25,038	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,474,790	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,656,251	0.000000	0.000000	193,715	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	951,847	0.000000	0.000000	1,830	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	5,133,101	0.000000	0.000000	0	76.02
76.03	03140	CARDIOLOGY	0	11,907,099	0.000000	0.000000	20,984	76.03
76.97	07697	CARDIAC REHABILITATION	0	1,065,387	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,028,550	0.000000	0.000000	8,073	90.00
91.00	09100	EMERGENCY	0	20,346,052	0.000000	0.000000	158,577	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,361,945	0.000000	0.000000	11,760	92.00
200.00		Total (lines 50-199)	0	332,968,146			1,388,963	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/18/2016 10:54 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	794	0		54.00
57.00	05700	CT SCAN	0	2,939	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	ANCILLARY	0	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0		76.02
76.03	03140	CARDIOLOGY	0	688	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	295	0		90.00
91.00	09100	EMERGENCY	0	2,818	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	7,534	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/18/2016 10:54 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.116539	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.134654	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.012248	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197440	794	0	0	157	54.00
57.00	05700	CT SCAN	0.029777	2,939	0	0	88	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.079576	0	0	0	0	58.00
60.00	06000	LABORATORY	0.137223	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.226202	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.170912	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.270715	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.238396	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236011	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.224158	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.690217	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.501881	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.283697	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218589	0	0	720	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.102714	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.091222	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.116567	688	0	0	80	76.03
76.97	07697	CARDIAC REHABILITATION	0.480765	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.440886	295	0	0	130	90.00
91.00	09100	EMERGENCY	0.138922	2,818	0	0	391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.465409	0	0	0	0	92.00
200.00		Subtotal (see instructions)		7,534	0	720	846	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		7,534	0	720	846	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/18/2016 10:54 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	157		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0		76.02
76.03	03140	CARDIOLOGY	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	157		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	157		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/18/2016 10:54 am

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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/18/2016 10:54 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	68,165,342	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	12,989,074	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	17,540,714	0.000000	0.000000	3,362	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,607,138	0.000000	0.000000	70,800	54.00
57.00	05700	CT SCAN	0	23,637,384	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	15,528,460	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	25,618,895	0.000000	0.000000	448,912	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	2,237,474	0.000000	0.000000	23,098	63.00
64.00	06400	INTRAVENOUS THERAPY	0	9,125,799	0.000000	0.000000	412	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,690,786	0.000000	0.000000	574,454	65.00
66.00	06600	PHYSICAL THERAPY	0	6,915,278	0.000000	0.000000	2,666,128	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,454,811	0.000000	0.000000	419,167	67.00
68.00	06800	SPEECH PATHOLOGY	0	575,273	0.000000	0.000000	82,949	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	940,699	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	24,015,997	0.000000	0.000000	8,877	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,474,790	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,656,251	0.000000	0.000000	572,794	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	951,847	0.000000	0.000000	1,050	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	5,133,101	0.000000	0.000000	0	76.02
76.03	03140	CARDIOLOGY	0	11,907,099	0.000000	0.000000	10,290	76.03
76.97	07697	CARDIAC REHABILITATION	0	1,065,387	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,028,550	0.000000	0.000000	5,934	90.00
91.00	09100	EMERGENCY	0	20,346,052	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,361,945	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	332,968,146			4,888,227	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/18/2016 10:54 am

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)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	ANCILLARY	0	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0		76.02
76.03	03140	CARDIOLOGY	0	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	858,562	0	858,562	15,798	54.35	30.00
31.00	INTENSIVE CARE UNIT	174,473		174,473	1,600	109.05	31.00
40.00	SUBPROVIDER - IPF	195,946	0	195,946	4,579	42.79	40.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	208,127		208,127	6,373	32.66	44.00
200.00	Total (lines 30-199)	1,437,108		1,437,108	28,350		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	655	35,599	30.00
31.00	INTENSIVE CARE UNIT	61	6,652	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	716	42,251	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,422,904	68,165,342	0.020874	0	0	50.00
51.00	05100	RECOVERY ROOM	23,658	12,989,074	0.001821	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	48,240	17,540,714	0.002750	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	521,827	19,607,138	0.026614	0	0	54.00
57.00	05700	CT SCAN	139,657	23,637,384	0.005908	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	503,233	15,528,460	0.032407	0	0	58.00
60.00	06000	LABORATORY	248,201	25,618,895	0.009688	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	19,371	2,237,474	0.008658	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	51,580	9,125,799	0.005652	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	144,471	6,690,786	0.021593	0	0	65.00
66.00	06600	PHYSICAL THERAPY	21,612	6,915,278	0.003125	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,724	1,454,811	0.001872	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	937	575,273	0.001629	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	93,707	940,699	0.099614	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	245,119	24,015,997	0.010206	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,916	22,474,790	0.003556	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	155,273	25,656,251	0.006052	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	5,592	951,847	0.005875	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	271,146	5,133,101	0.052823	0	0	76.02
76.03	03140	CARDIOLOGY	297,631	11,907,099	0.024996	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	102,041	1,065,387	0.095778	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	243,036	7,028,550	0.034578	0	0	90.00
91.00	09100	EMERGENCY	228,768	20,346,052	0.011244	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	127,224	3,361,945	0.037842	0	0	92.00
200.00		Total (lines 50-199)	4,997,868	332,968,146		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/18/2016 10:54 am

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	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,798	0.00	655	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,600	0.00	61	0		31.00
40.00	04000	SUBPROVIDER - IPF	4,579	0.00	0	0		40.00
43.00	04300	NURSERY	0	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	6,373	0.00	0	0		44.00
200.00		Total (lines 30-199)	28,350		716	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	68,165,342	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	12,989,074	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	17,540,714	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,607,138	0.000000	0.000000	0	54.00
57.00	05700	CT SCAN	0	23,637,384	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	15,528,460	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	25,618,895	0.000000	0.000000	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	2,237,474	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	9,125,799	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,690,786	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,915,278	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,454,811	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	575,273	0.000000	0.000000	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	940,699	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	24,015,997	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,474,790	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,656,251	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	951,847	0.000000	0.000000	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	5,133,101	0.000000	0.000000	0	76.02
76.03	03140	CARDIOLOGY	0	11,907,099	0.000000	0.000000	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	1,065,387	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,028,550	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	20,346,052	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,361,945	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	332,968,146			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	ANCILLARY	0	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0		76.02
76.03	03140	CARDIOLOGY	0	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II | Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,422,904	68,165,342	0.020874	0	0	50.00
51.00	05100	RECOVERY ROOM	23,658	12,989,074	0.001821	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	48,240	17,540,714	0.002750	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	521,827	19,607,138	0.026614	0	0	54.00
57.00	05700	CT SCAN	139,657	23,637,384	0.005908	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	503,233	15,528,460	0.032407	0	0	58.00
60.00	06000	LABORATORY	248,201	25,618,895	0.009688	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	19,371	2,237,474	0.008658	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	51,580	9,125,799	0.005652	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	144,471	6,690,786	0.021593	0	0	65.00
66.00	06600	PHYSICAL THERAPY	21,612	6,915,278	0.003125	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,724	1,454,811	0.001872	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	937	575,273	0.001629	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	93,707	940,699	0.099614	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	245,119	24,015,997	0.010206	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,916	22,474,790	0.003556	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	155,273	25,656,251	0.006052	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	5,592	951,847	0.005875	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	271,146	5,133,101	0.052823	0	0	76.02
76.03	03140	CARDIOLOGY	297,631	11,907,099	0.024996	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	102,041	1,065,387	0.095778	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	243,036	7,028,550	0.034578	0	0	90.00
91.00	09100	EMERGENCY	228,768	20,346,052	0.011244	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,361,945	0.000000	0	0	92.00
200.00		Total (lines 50-199)	4,870,644	332,968,146		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	68,165,342	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	12,989,074	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	17,540,714	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,607,138	0.000000	0.000000	0	54.00
57.00	05700	CT SCAN	0	23,637,384	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	15,528,460	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	25,618,895	0.000000	0.000000	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	2,237,474	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	9,125,799	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,690,786	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,915,278	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,454,811	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	575,273	0.000000	0.000000	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	940,699	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	24,015,997	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,474,790	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,656,251	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	951,847	0.000000	0.000000	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	5,133,101	0.000000	0.000000	0	76.02
76.03	03140	CARDIOLOGY	0	11,907,099	0.000000	0.000000	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	1,065,387	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,028,550	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	20,346,052	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,361,945	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	332,968,146			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	ANCILLARY	0	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0		76.02
76.03	03140	CARDIOLOGY	0	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	68,165,342	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	12,989,074	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	17,540,714	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,607,138	0.000000	0.000000	0	54.00
57.00	05700	CT SCAN	0	23,637,384	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	15,528,460	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	25,618,895	0.000000	0.000000	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	2,237,474	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	9,125,799	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,690,786	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,915,278	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,454,811	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	575,273	0.000000	0.000000	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	940,699	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	24,015,997	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,474,790	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,656,251	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	951,847	0.000000	0.000000	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	5,133,101	0.000000	0.000000	0	76.02
76.03	03140	CARDIOLOGY	0	11,907,099	0.000000	0.000000	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	1,065,387	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,028,550	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	20,346,052	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,361,945	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	332,968,146			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | 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)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	ANCILLARY	0	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0		76.02
76.03	03140	CARDIOLOGY	0	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/18/2016 10:54 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,798	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,798	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)	13,457	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	7,286	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	10,559,126	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)	10,559,126	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	10,559,126	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	668.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,869,817	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)	4,869,817	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/18/2016 10:54 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,481,686	1,600	1,551.05	863	1,338,556	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)	11,118,150	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	17,326,523	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)	490,104	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	710,345	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,200,449	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	16,126,074	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,341	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	668.38	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,564,678	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/18/2016 10:54 am

Title XVIII | Hospital | 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	858,562	10,559,126	0.081310	1,564,678	127,224	90.00
91.00	Nursing School cost	0	10,559,126	0.000000	1,564,678	0	91.00
92.00	Allied health cost	0	10,559,126	0.000000	1,564,678	0	92.00
93.00	All other Medical Education	0	10,559,126	0.000000	1,564,678	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 14S013	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/18/2016 10:54 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,579	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,579	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)	4,579	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)	3,280	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,861,274	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)	2,861,274	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,861,274	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	624.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,049,574	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)	2,049,574	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/18/2016 10:54 am

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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	228,395	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,277,969	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)	140,351	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	14,222	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	154,573	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,123,396	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: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1

Component CCN: 14S013 | Date/Time Prepared: 5/18/2016 10:54 am

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	195,946	2,861,274	0.068482	0	0	90.00
91.00	Nursing School cost	0	2,861,274	0.000000	0	0	91.00
92.00	Allied health cost	0	2,861,274	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,861,274	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/18/2016 10:54 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,373	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,373	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)	6,373	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)	3,912	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,370,513	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)	2,370,513	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,370,513	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		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: 140013 | Component CCN: 145579 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/18/2016 10:54 am

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)	2,370,513	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	371.96	71.00
72.00	Program routine service cost (line 9 x line 71)	1,455,108	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)	1,455,108	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)	1,455,108	83.00
84.00	Program inpatient ancillary services (see instructions)	1,123,129	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)	2,578,237	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: 140013 Component CCN: 145579	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/18/2016 10:54 am
	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: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,798	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,798	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)	13,457	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)	655	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	10,559,126	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)	10,559,126	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	10,559,126	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	668.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	437,789	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)	437,789	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	13	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,481,686	1,600	1,551.05	61	94,614	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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	532,403	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)	42,251	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	42,251	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	490,152	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,341	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	668.38	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,564,678	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | Hospital | 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	858,562	10,559,126	0.081310	1,564,678	127,224	90.00
91.00	Nursing School cost	0	10,559,126	0.000000	1,564,678	0	91.00
92.00	Allied health cost	0	10,559,126	0.000000	1,564,678	0	92.00
93.00	All other Medical Education	0	10,559,126	0.000000	1,564,678	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 14S013	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/18/2016 10:54 am
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,579	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,579	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)	4,579	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)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,861,274	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)	2,861,274	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,861,274	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	624.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	0	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	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: 140013 | Component CCN: 14S013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | 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	195,946	2,861,274	0.068482	0	0	90.00
91.00	Nursing School cost	0	2,861,274	0.000000	0	0	91.00
92.00	Allied health cost	0	2,861,274	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,861,274	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/18/2016 10:54 am
	Title XIX	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,373	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,373	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)	6,373	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)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,370,513	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)	2,370,513	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,370,513	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		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: 140013 | Component CCN: 145579 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/18/2016 10:54 am

Title XIX | 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)	2,370,513	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	371.96	71.00
72.00	Program routine service cost (line 9 x line 71)	0	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)	0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	208,127	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	32.66	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)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	0	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)	0	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: 140013 Component CCN: 145579	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/18/2016 10:54 am
	Title XIX	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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/18/2016 10:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		11,896,462		30.00
31.00	03100	INTENSIVE CARE UNIT		3,853,560		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.116539	9,052,833	1,055,008	50.00
51.00	05100	RECOVERY ROOM	0.134654	1,992,227	268,261	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.012766	1,881,134	24,015	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197440	2,404,085	474,663	54.00
57.00	05700	CT SCAN	0.029777	3,031,248	90,261	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.079576	1,129,984	89,920	58.00
60.00	06000	LABORATORY	0.137223	4,737,863	650,144	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.226202	650,662	147,181	63.00
64.00	06400	INTRAVENOUS THERAPY	0.170912	997,082	170,413	64.00
65.00	06500	RESPIRATORY THERAPY	0.270715	1,985,543	537,516	65.00
66.00	06600	PHYSICAL THERAPY	0.238396	1,227,656	292,668	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236011	397,154	93,733	67.00
68.00	06800	SPEECH PATHOLOGY	0.224158	243,526	54,588	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.690217	61,194	42,237	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.501881	6,200,697	3,112,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.283697	5,909,547	1,676,521	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218589	6,484,882	1,417,524	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.102714	208,348	21,400	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.091222	873,966	79,725	76.02
76.03	03140	CARDIOLOGY	0.116567	2,942,156	342,958	76.03
76.97	07697	CARDIAC REHABILITATION	0.480765	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.440886	183,477	80,892	90.00
91.00	09100	EMERGENCY	0.138922	2,145,069	297,997	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.465409	211,670	98,513	92.00
200.00		Total (sum of lines 50-94 and 96-98)		54,952,003	11,118,150	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)		54,952,003		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/18/2016 10:54 am

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	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		6,792,485		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.116539	5,174	603	50.00
51.00	05100	RECOVERY ROOM	0.134654	1,260	170	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.012766	2,041	26	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197440	63,288	12,496	54.00
57.00	05700	CT SCAN	0.029777	241,080	7,179	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.079576	28,485	2,267	58.00
60.00	06000	LABORATORY	0.137223	344,780	47,312	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.226202	5,486	1,241	63.00
64.00	06400	INTRAVENOUS THERAPY	0.170912	13,760	2,352	64.00
65.00	06500	RESPIRATORY THERAPY	0.270715	90,343	24,457	65.00
66.00	06600	PHYSICAL THERAPY	0.238396	146,429	34,908	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236011	12,622	2,979	67.00
68.00	06800	SPEECH PATHOLOGY	0.224158	12,936	2,900	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.690217	1,302	899	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.501881	25,038	12,566	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.283697	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218589	193,715	42,344	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.102714	1,830	188	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.091222	0	0	76.02
76.03	03140	CARDIOLOGY	0.116567	20,984	2,446	76.03
76.97	07697	CARDIAC REHABILITATION	0.480765	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.440886	8,073	3,559	90.00
91.00	09100	EMERGENCY	0.138922	158,577	22,030	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.465409	11,760	5,473	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,388,963	228,395	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)		1,388,963		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3

Component CCN: 145579 | Date/Time Prepared: 5/18/2016 10:54 am

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	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.116539	0	0	50.00
51.00	05100	RECOVERY ROOM	0.134654	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.012248	3,362	41	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197440	70,800	13,979	54.00
57.00	05700	CT SCAN	0.029777	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.079576	0	0	58.00
60.00	06000	LABORATORY	0.137223	448,912	61,601	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.226202	23,098	5,225	63.00
64.00	06400	INTRAVENOUS THERAPY	0.170912	412	70	64.00
65.00	06500	RESPIRATORY THERAPY	0.270715	574,454	155,513	65.00
66.00	06600	PHYSICAL THERAPY	0.238396	2,666,128	635,594	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236011	419,167	98,928	67.00
68.00	06800	SPEECH PATHOLOGY	0.224158	82,949	18,594	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.690217	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.501881	8,877	4,455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.283697	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218589	572,794	125,206	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.102714	1,050	108	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.091222	0	0	76.02
76.03	03140	CARDIOLOGY	0.116567	10,290	1,199	76.03
76.97	07697	CARDIAC REHABILITATION	0.480765	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.440886	5,934	2,616	90.00
91.00	09100	EMERGENCY	0.138922	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.465409	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,888,227	1,123,129	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)		4,888,227		202.00

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		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		9,714,584		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,336,955		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)		454,557		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)		154.59		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.72		30.00
31.00	Percentage of Medicaid patient days (see instructions)		4.73		31.00
32.00	Sum of lines 30 and 31		7.45		32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00		33.00
34.00	Disproportionate share adjustment (see instructions)		0		34.00

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			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)		0.000038866	0.000041953	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 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 an 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)		13,506,096		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)		13,506,096		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,083,291		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 intructions)		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)		14,589,387		59.00
60.00	Primary payer payments		10,229		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		14,579,158		61.00
62.00	Deductibles billed to program beneficiaries		1,844,800		62.00
63.00	Coinsurance billed to program beneficiaries		19,215		63.00
64.00	Allowable bad debts (see instructions)		151,208		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		98,285		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		116,880		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		12,813,428		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)		7,316		70.93
70.94	HRR adjustment amount (see instructions)		-105,020		70.94
70.95	Recovery of accelerated depreciation		0		70.95

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			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		12,715,724		71.00
71.01	Sequestration adjustment (see instructions)		254,314		71.01
72.00	Interim payments		12,469,600		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)		-8,190		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		10,000		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		35,525		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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/18/2016 10:54 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	9,714,584	0	9,714,584	0	9,714,584	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,336,955	0	0	3,336,955	3,336,955	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	454,557	0	379,527	75,031	454,558	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	13,506,096	0	10,094,110	3,411,986	13,506,096	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,506,096	0	10,094,110	3,411,986	13,506,096	15.00
16.00	Payment for inpatient program capital	50.00	1,083,291	0	807,105	276,186	1,083,291	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	10,901,215	3,688,172	14,589,387	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,032,078	0	767,378	264,700	1,032,078	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	35,525	0	35,525	7,463	42,988	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0152	0.0152	0.0152	0.0152		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	15,688	0	11,665	4,023	15,688	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,083,291	0	807,105	276,186	1,083,291	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/18/2016 10:54 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	9,714,584	9,714,584		9,714,584	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,336,955		3,336,955	3,336,955	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	454,557	379,527	75,031	454,558	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	13,506,096	10,094,110	3,411,986	13,506,096	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,506,096	10,094,110	3,411,986	13,506,096	15.00
16.00	Payment for inpatient program capital	50.00	1,083,291	814,568	268,723	1,083,291	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			10,908,678	3,680,709	14,589,387	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/18/2016 10:54 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,032,078	767,378	264,700	1,032,078	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	35,525	35,525	0	35,525	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0152	0.0152	0.0152		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	15,688	11,665	4,023	15,688	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,083,291	814,568	268,723	1,083,291	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	7,316	-5,414	12,730	7,316	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-105,020	-79,659	-25,361	-105,020	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/18/2016 10:54 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	71,629	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	10,021,875	2.00
3.00	PPS payments	8,023,294	3.00
4.00	Outlier payment (see instructions)	227,889	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	71,629	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	267,642	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)	267,642	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis 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)	267,642	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	196,013	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	71,629	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	8,251,183	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	40,318	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,616,260	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	6,666,234	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	6,666,234	30.00
31.00	Primary payer payments	2,963	31.00
32.00	Subtotal (line 30 minus line 31)	6,663,271	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	147,941	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	96,162	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	133,626	36.00
37.00	Subtotal (see instructions)	6,759,433	37.00
38.00	MSP-LCC reconciliation amount from PS&R	15	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	6,759,418	40.00
40.01	Sequestration adjustment (see instructions)	135,188	40.01
41.00	Interim payments	6,583,755	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	40,475	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	227,889	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013 Component CCN: 14S013	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/18/2016 10:54 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	157	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	846	2.00
3.00	PPS payments	1,339	3.00
4.00	Outlier payment (see instructions)	0	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)	157	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	720	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)	720	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis 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)	720	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	563	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)	157	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)	1,339	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	255	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,241	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)	1,241	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,241	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,241	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,241	40.00
40.01	Sequestration adjustment (see instructions)	25	40.01
41.00	Interim payments	1,232	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-16	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/18/2016 10:54 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		12,515,030		6,713,799	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	08/14/2015	45,430	08/14/2015	130,044	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)		-45,430		-130,044	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)		12,469,600		6,583,755	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		40,475	6.01
6.02	SETTLEMENT TO PROGRAM		8,190		0	6.02
7.00	Total Medicare program liability (see instructions)		12,461,410		6,624,230	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	National Government Services, Inc.	06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/18/2016 10:54 am

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		2,502,047		1,232	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)		2,502,047		1,232	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		27,687		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		16	6.02
7.00	Total Medicare program liability (see instructions)		2,529,734		1,216	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	National Government Services, Inc.	06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140013	Period: From 01/01/2015	Worksheet E-1 Part I
Component CCN: 145579	To 12/31/2015	Date/Time Prepared: 5/18/2016 10:54 am
Title XVIII	Skilled Nursing Facility	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		1,644,425		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)		1,644,425		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		629		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,645,054		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	National Government Services, Inc.	06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140013	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/18/2016 10:54 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	3,775	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	8,149	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3,518	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	15,057	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	382,172,449	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	788,715	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)	980,409	8.00
9.00	Sequestration adjustment amount (see instructions)	19,608	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	960,801	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	908,612	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)	52,189	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013 Component CCN: 14S013	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part II Date/Time Prepared: 5/18/2016 10:54 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,598,450	1.00
2.00	Net IPF PPS Outlier Payments	180,869	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 instuctions)	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 instuctions)	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)	12.545205	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) 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)	2,779,319	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)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,779,319	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,779,319	18.00
19.00	Deductibles	189,996	19.00
20.00	Subtotal (line 18 minus line 19)	2,589,323	20.00
21.00	Coinsurance	36,203	21.00
22.00	Subtotal (line 20 minus line 21)	2,553,120	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	43,447	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	28,241	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	39,788	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,581,361	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)	2,581,361	31.00
31.01	Sequestration adjustment (see instructions)	51,627	31.01
32.00	Interim payments	2,502,047	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)	27,687	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	180,869	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: 140013 Component CCN: 145579	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VI Date/Time Prepared: 5/18/2016 10:54 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,760,792	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)	1,760,792	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	82,807	7.00
8.00	Allowable bad debts (see instructions)	988	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	642	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)	1,678,627	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	1,678,627	15.00
15.01	Sequestration adjustment (see instructions)	33,573	15.01
16.00	Interim payments	1,644,425	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)	629	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: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/18/2016 10:54 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	8,165,648	0	0	0	1.00
2.00	Temporary investments	1,331,795	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,319,960	0	0	0	4.00
5.00	Other receivable	2,805,111	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,067,000	0	0	0	7.00
8.00	Prepaid expenses	736,373	0	0	0	8.00
9.00	Other current assets	1,883,427	0	0	0	9.00
10.00	Due from other funds	11,955,548	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	40,264,862	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	6,081,907	0	0	0	12.00
13.00	Land improvements	6,382,159	0	0	0	13.00
14.00	Accumulated depreciation	-11,490,450	0	0	0	14.00
15.00	Buildings	61,532,028	0	0	0	15.00
16.00	Accumulated depreciation	-84,020,733	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	19,953,863	0	0	0	19.00
20.00	Accumulated depreciation	-35,411,255	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	157,945,434	0	0	0	23.00
24.00	Accumulated depreciation	-88,492,845	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	32,480,108	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	6,320,560	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	6,591,972	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,912,532	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	85,657,502	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,623,392	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,507,570	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,310,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	33,893,512	0	0	0	43.00
44.00	Other current liabilities	2,216,628	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	44,551,102	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	22,451,805	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	27,639,280	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	50,091,085	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	94,642,187	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-8,984,685				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)	-8,984,685	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	85,657,502	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/18/2016 10:54 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-10,308,035		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,938,338				2.00
3.00	Total (sum of line 1 and line 2)		-4,369,697		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	CHANGE IN TEMP & PERM REST	24,000		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		24,000		0		10.00
11.00	Subtotal (line 3 plus line 10)		-4,345,697		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	CHANGE IN UNRESTRICTED FUND BALANCE	4,638,988		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		4,638,988		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-8,984,685		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 TEMP & PERM REST		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	CHANGE IN UNRESTRICTED FUND BALANCE		0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140013 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/18/2016 10:54 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	22,389,078		22,389,078	1.00
2.00	SUBPROVIDER - IPF	9,502,277		9,502,277	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	10,368,985		10,368,985	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)	42,260,340		42,260,340	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	7,242,949		7,242,949	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)	7,242,949		7,242,949	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	49,503,289		49,503,289	17.00
18.00	Ancillary services	114,798,305	0	114,798,305	18.00
19.00	Outpatient services	0	118,567,853	118,567,853	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS	0	104,084,677	104,084,677	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	164,301,594	222,652,530	386,954,124	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		69,733,746		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		69,733,746		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140013	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prepared: 5/18/2016 10:54 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	386,954,124	1.00
2.00	Less contractual allowances and discounts on patients' accounts	297,762,961	2.00
3.00	Net patient revenues (line 1 minus line 2)	89,191,163	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	69,733,746	4.00
5.00	Net income from service to patients (line 3 minus line 4)	19,457,417	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-18,564	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	-28,846	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISC REVENUE	4,692,379	24.00
25.00	Total other income (sum of lines 6-24)	4,644,969	25.00
26.00	Total (line 5 plus line 25)	24,102,386	26.00
27.00	PEORIA HOME OFFICE EXPENSES	18,164,048	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	18,164,048	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,938,338	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140013	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/18/2016 10:54 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,032,078	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	35,525	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)	41.49	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	2.72	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	4.73	8.00
9.00	Sum of lines 7 and 8	7.45	9.00
10.00	Allowable disproportionate share percentage (see instructions)	1.52	10.00
11.00	Disproportionate share adjustment (see instructions)	15,688	11.00
12.00	Total prospective capital payments (see instructions)	1,083,291	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00