

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: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/30/2016 11:56 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 5/30/2016 Time: 11:56 am	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SSM HEALTH ST. MARY'S HOSPITAL (140034) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	130,030	102,188	-18,079	0	1.00
2.00 Subprovider - IPF	0	24,566	-67		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
12.20 OUTPATIENT PHYSICAL THERAPY I	0		0		0	12.20
200.00 Total	0	154,596	102,121	-18,079	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-MEDI CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 5/30/2016 11:51 am				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL Zip Code: 62801-		4.00 County: MARI ON				
1.00 Street: 400 NORTH PLEASANT AVENUE		2.00 City: CENTRALIA								
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
3.00 Hospital and Hospital -Based Component Identification:										
3.00	Hospital	SSM HEALTH ST. MARY'S HOSPITAL	140034	99914	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF	SSM HEALTH ST. MARYS PSYCH	14S034	99914	4	01/01/2002	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									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
17.10	Hospital -Based (CORF) I									17.10
17.20	Hospital -Based (OPT) I	ST MARYS WORK SAFETY INSTITUTE	146668	99914		03/08/2000	N	O	N	17.20
17.30	Hospital -Based (OOT) I									17.30
17.40	Hospital -Based (OSP) I									17.40
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2015	12/31/2015		20.00	
21.00	Type of Control (see instructions)					1				21.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N			22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3		N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3,036	385	0	4	278	123			24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 5/30/2016 11:51 am			
		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		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00	
		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.					2		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.					2		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.					1		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.					01/01/2015	12/31/2015	38.00	
		Y/N		Y/N					
		1.00		2.00					
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
		V		XVII		XIX			
		1.00		2.00		3.00			
		Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
		Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)					N			60.00
		Y/N		IME		Direct GME			
		1.00		2.00		3.00			
						4.00			
						5.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					N		0.00	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 5/30/2016 11:51 am	
	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)	0.00	0.00				61.03
61.04	Enter the number of unweighted primary care/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
	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140034

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

Worksheet S-2
Part I
Date/Time Prepared:
5/30/2016 11:51 am

		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		
				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	
70.00	Inpatient Psychiatric Facility PPS 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	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		0	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

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				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
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
Rural Providers					
105.00	Does this hospital qualify as a critical access hospital (CAH)?			N	105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N	108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				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.	Y			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.	1			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	51,150	8,268	0	118.01

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		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	Y	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	
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	269020	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: SSM HEALTH	Contractor's Name: A		Contractor's Number: 05301	
142.00	Street: 10101 WOODFIELD LANE	PO Box:			
143.00	City: ST. LOUIS	State: MO		Zip Code: 63132	
			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
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
161.10	CORF		N	N	N
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 5/30/2016 11:51 am		
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	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)							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)				08/02/2015	10/30/2015	170.00	
							1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)						N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/30/2016 11:51 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)	Y			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	Type	Date
			1.00	2.00	3.00
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	Legal Oper.	
			1.00	2.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	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)	Y	04/12/2015	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140034

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

Worksheet S-2
Part II
Date/Time Prepared:
5/30/2016 11:51 am

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		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.		Y		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.	BRIAN		SCHMEIDLER	41.00
42.00	Enter the employer/company name of the cost report preparer.	SSM HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-989-3524		BRIAN_SCHMEIDLER@SSMHC.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/12/2015	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.	DIRECTOR - GOVERNEMENT REIMBURSEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140034

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2016 11:51 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	84	30,736	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)		84	30,736	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		96	35,116	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	12	4,380		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		108				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: 140034

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2016 11:51 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,291	2,166	13,473			1.00
2.00 HMO and other (see instructions)	798	611				2.00
3.00 HMO IPF Subprovider	0	176				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	9,291	2,166	13,473			7.00
8.00 INTENSIVE CARE UNIT	1,033	405	2,558			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		521	566			13.00
14.00 Total (see instructions)	10,324	3,092	16,597	0.00	582.90	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	622	1,578	2,707	0.00	18.49	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
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	601.39	27.00
28.00 Observation Bed Days		610	2,268			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			176			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	123	163			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: 140034

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2016 11:51 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	2,403	1,026	3,980	1.00
2.00 HMO and other (see instructions)				209	0		2.00
3.00 HMO IPF Subprovider					36		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		2,403	1,026	3,980	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0		102	348	574	16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
25.10 CMHC - CORF	0.00						25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00						25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00						25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00						25.40
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: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet S-3 Part II Date/Time Prepared: 5/30/2016 11:51 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	30,811,069	0	30,811,069	1,227,127.00	25.11	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		189,955	0	189,955	2,035.70	93.31	3.00
4.00	Physician-Part A - Administrative		255,659	0	255,659	1,707.00	149.77	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		49,279	0	49,279	328.00	150.24	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	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,187,420	32,996	1,220,416	45,116.82	27.05	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		542,830	0	542,830	9,603.94	56.52	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		223,512	0	223,512	1,407.09	158.85	13.00
14.00	Home office salaries & wage-related costs		5,950,389	0	5,950,389	128,317.00	46.37	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		16,664,559	0	16,664,559			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		675,771	0	675,771			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		108,105	0	108,105			21.00
22.00	Physician Part A - Administrative		20,850	0	20,850			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		4,018	0	4,018			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	3,780,923	-32,996	3,747,927	118,610.00	31.60	27.00
28.00	Administrative & General under contract (see inst.)		328,602	0	328,602	3,280.00	100.18	28.00
29.00	Maintenance & Repairs	6.00	822,079	-433,866	388,213	19,449.00	19.96	29.00
30.00	Operation of Plant	7.00	0	433,866	433,866	21,737.00	19.96	30.00
31.00	Laundry & Linen Service	8.00	110,420	0	110,420	7,990.00	13.82	31.00
32.00	Housekeeping	9.00	1,009,712	0	1,009,712	75,919.00	13.30	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	861,480	-530,252	331,228	20,435.00	16.21	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	530,252	530,252	37,473.70	14.15	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	652,557	0	652,557	19,893.29	32.80	38.00
39.00	Central Services and Supply	14.00	173,935	-173,935	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,133,019	0	1,133,019	31,262.46	36.24	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140034

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

Worksheet S-3
Part II
Date/Time Prepared:
5/30/2016 11:51 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 582,660	0	582,660	30,640.34	19.02	41.00
42.00	Social Service	17.00 9,593	0	9,593	400.90	23.93	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part III Date/Time Prepared: 5/30/2016 11:51 am
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	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	30,900,437	0	30,900,437	1,228,043.30	25.16	1.00
2.00	Excluded area salaries (see instructions)	1,187,420	32,996	1,220,416	45,116.82	27.05	2.00
3.00	Subtotal salaries (line 1 minus line 2)	29,713,017	-32,996	29,680,021	1,182,926.48	25.09	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,716,731	0	6,716,731	139,328.03	48.21	4.00
5.00	Subtotal wage-related costs (see inst.)	16,685,409	0	16,685,409	0.00	56.22	5.00
6.00	Total (sum of lines 3 thru 5)	53,115,157	-32,996	53,082,161	1,322,254.51	40.15	6.00
7.00	Total overhead cost (see instructions)	9,464,980	-206,931	9,258,049	387,090.69	23.92	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2016 11:51 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			226,885 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			2,738,388 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			13,366,202 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			186,000 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			77,345 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			4,900 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			78,195 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			451,465 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			1,983,437 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			15,824 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			203,628 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			19,332,269 24.00
Part B - Other than Core Related Cost				
25.00	OTHER NON-CORE BENEFITS			65,902 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part V Date/Time Prepared: 5/30/2016 11:51 am
Cost Center Description			Contract Labor	Benefit Cost
PART V - Contract Labor and Benefit Cost			1.00	2.00
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0
2.00	Hospital		0	0
3.00	Subprovider - IPF		0	0
4.00	Subprovider - IRF			
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA			
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
16.10	Hospital-Based-CMHC 10		0	0
16.20	Hospital-Based-CMHC 20		0	0
16.30	Hospital-Based-CMHC 30		0	0
16.40	Hospital-Based-CMHC 40		0	0
17.00	Renal Dialysis			
18.00	Other		0	0

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 5/30/2016 11:51 am
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				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.301467		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		11,945,988		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		5,615,236		5.00
6.00	Medicaid charges		73,180,537		6.00
7.00	Medicaid cost (line 1 times line 6)		22,061,517		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)		4,500,293		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		4,500,293		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	1,837,595	404,233	2,241,828	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	553,974	121,863	675,837	21.00
22.00	Partial payment by patients approved for charity care	6,838	43,578	50,416	22.00
23.00	Cost of charity care (line 21 minus line 22)	547,136	78,285	625,421	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)		3,216,512		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		790,783		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		2,425,729		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		731,277		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,356,698		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,856,991		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140034

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

Worksheet A
Date/Time Prepared:
5/30/2016 11:51 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		1,576,330	1,576,330	183,740	1,760,070	1.00
2.00	00200		2,085,923	2,085,923	49,318	2,135,241	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	0	13,472,008	13,472,008	0	13,472,008	4.00
5.00	00500	3,780,923	21,125,797	24,906,720	-326,090	24,580,630	5.00
6.00	00600	822,079	2,368,400	3,190,479	-1,883,487	1,306,992	6.00
6.01	00601	0	1,041,658	1,041,658	0	1,041,658	6.01
7.00	00700	0	0	0	2,203,155	2,203,155	7.00
8.00	00800	110,420	246,132	356,552	-1,212	355,340	8.00
9.00	00900	1,009,712	297,304	1,307,016	-124,517	1,182,499	9.00
10.00	01000	861,480	656,845	1,518,325	-1,002,531	515,794	10.00
11.00	01100	0	0	0	1,002,464	1,002,464	11.00
13.00	01300	652,557	65,311	717,868	0	717,868	13.00
14.00	01400	173,935	29,754	203,689	2,303,060	2,506,749	14.00
15.00	01500	1,133,019	4,003,901	5,136,920	-3,766,641	1,370,279	15.00
16.00	01600	582,660	334,481	917,141	-1,712	915,429	16.00
17.00	01700	9,593	141	9,734	0	9,734	17.00
19.00	01900	189,955	0	189,955	0	189,955	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,285,636	767,001	7,052,637	-1,170,271	5,882,366	30.00
31.00	03100	1,931,854	797,865	2,729,719	-151,015	2,578,704	31.00
40.00	04000	987,307	73,435	1,060,742	-8,567	1,052,175	40.00
43.00	04300	0	0	0	397,013	397,013	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,936,933	2,489,076	4,426,009	-1,548,324	2,877,685	50.00
52.00	05200	0	0	0	307,869	307,869	52.00
53.00	05300	13	1,571,882	1,571,895	-101,650	1,470,245	53.00
54.00	05400	1,512,968	958,928	2,471,896	-37,304	2,434,592	54.00
54.01	05401	103,826	1,025	104,851	-397	104,454	54.01
56.01	03470	159,192	458,652	617,844	-3,106	614,738	56.01
57.00	05700	291,849	67,633	359,482	-37,976	321,506	57.00
58.00	05800	157,597	46,128	203,725	-28,516	175,209	58.00
59.00	05900	225,237	163,886	389,123	-83,033	306,090	59.00
60.00	06000	1,374,647	2,748,756	4,123,403	-62,763	4,060,640	60.00
64.00	06400	281,062	59,633	340,695	-47,467	293,228	64.00
65.00	06500	664,272	149,168	813,440	4,827	818,267	65.00
65.98	06501	0	0	0	60,666	60,666	65.98
66.00	06600	1,292,777	220,969	1,513,746	-7,486	1,506,260	66.00
68.00	06800	107,809	2,901	110,710	1,767	112,477	68.00
69.00	06900	664,006	344,898	1,008,904	-14,785	994,119	69.00
70.01	07001	301,341	294,856	596,197	-15,470	580,727	70.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	690,075	690,075	72.00
73.00	07300	0	0	0	3,766,641	3,766,641	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	327,542	99,647	427,189	-110,955	316,234	90.00
90.01	09002	22,750	385	23,135	0	23,135	90.01
90.02	09001	254,685	13,606	268,291	-1,344	266,947	90.02
90.04	09003	133,204	437	133,641	0	133,641	90.04
91.00	09100	2,268,116	1,267,857	3,535,973	-318,075	3,217,898	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		30,610,956	59,902,609	90,513,565	115,901	90,629,466	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	19,008	854	19,862	0	19,862	190.00
192.00	19200	69,980	482,627	552,607	-4,267	548,340	192.00
193.05	19305	111,125	387,843	498,968	-180,019	318,949	193.05
193.06	19306	0	0	0	0	0	193.06
193.07	19307	0	0	0	68,385	68,385	193.07
193.08	19308	0	0	0	0	0	193.08
194.00	07951	0	0	0	0	0	194.00
194.01	07950	0	6,000	6,000	0	6,000	194.01
200.00		30,811,069	60,779,933	91,591,002	0	91,591,002	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140034

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

Worksheet A
Date/Time Prepared:
5/30/2016 11:51 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	454,265	2,214,335	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	897,261	3,032,502	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,405,445	9,066,563	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,766,486	17,814,144	5.00
6.00	00600	MAINTENANCE & REPAIRS	-5,800	1,301,192	6.00
6.01	00601	BIOMEDICAL SERVICES	-452,000	589,658	6.01
7.00	00700	OPERATION OF PLANT	0	2,203,155	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	355,340	8.00
9.00	00900	HOUSEKEEPING	-229	1,182,270	9.00
10.00	01000	DIETARY	-89,728	426,066	10.00
11.00	01100	CAFETERIA	-230,084	772,380	11.00
13.00	01300	NURSING ADMINISTRATION	-728	717,140	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	2,506,749	14.00
15.00	01500	PHARMACY	0	1,370,279	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,062	913,367	16.00
17.00	01700	SOCIAL SERVICE	0	9,734	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-189,955	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,365	5,881,001	30.00
31.00	03100	INTENSIVE CARE UNIT	-162	2,578,542	31.00
40.00	04000	SUBPROVIDER - I/PF	-1,225	1,050,950	40.00
43.00	04300	NURSERY	0	397,013	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-24,544	2,853,141	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	307,869	52.00
53.00	05300	ANESTHESIOLOGY	-1,396,341	73,904	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-930,263	1,504,329	54.00
54.01	05401	CARDIAC REHABILITATION	-22,698	81,756	54.01
56.01	03470	NUCLEAR MEDICINE	-24,452	590,286	56.01
57.00	05700	CT SCAN	0	321,506	57.00
58.00	05800	MRI	0	175,209	58.00
59.00	05900	CARDIAC CATHETERIZATION	-15,316	290,774	59.00
60.00	06000	LABORATORY	-489,471	3,571,169	60.00
64.00	06400	INTRAVENOUS THERAPY	0	293,228	64.00
65.00	06500	RESPIRATORY THERAPY	-33,060	785,207	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	0	60,666	65.98
66.00	06600	PHYSICAL THERAPY	-126,584	1,379,676	66.00
68.00	06800	SPEECH PATHOLOGY	0	112,477	68.00
69.00	06900	ELECTROCARDIOLOGY	-358,029	636,090	69.00
70.01	07001	NEUROLOGY	-260,578	320,149	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	-46,191	-46,191	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	690,075	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,766,641	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-190	316,044	90.00
90.01	09002	DIABETES EDUCATION	0	23,135	90.01
90.02	09001	PSYCH SERVICES	0	266,947	90.02
90.04	09003	ANTI COAGULATION CLINIC	0	133,641	90.04
91.00	09100	EMERGENCY	-807,230	2,410,668	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-15,328,690	75,300,776	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	19,862	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	548,340	192.00
193.05	19305	OTHER NON-REIMBURSABLE	0	318,949	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	0	193.06
193.07	19307	OUTSIDE PRINTING	0	68,385	193.07
193.08	19308	FOUNDATION	0	0	193.08
194.00	07951	AHEC	0	0	194.00
194.01	07950	OTHER NONREIMBURSABLE COST CENTERS	0	6,000	194.01
200.00		TOTAL (SUM OF LINES 118-199)	-15,328,690	76,262,312	200.00

RECLASSIFICATIONS

Provider CCN: 140034

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

Worksheet A-6
Date/Time Prepared:
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		Increases			
Cost Center		Line #	Salary	Other	
2.00	3.00	4.00	5.00		
A - RECLASS FROM OB TO NURSERY					
1.00	NURSERY	43.00	347,114	49,899	1.00
	O		347,114	49,899	
B - RECLASS FROM OB TO DELIVERY ROOM					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	269,174	38,695	1.00
	O		269,174	38,695	
C - RECLASS FROM DIETARY TO CAFETERIA					
1.00	CAFETERIA	11.00	530,252	472,212	1.00
	O		530,252	472,212	
F - INVENTORY COST TO CENTRAL SERVICES					
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	20,942	1.00
	TOTALS		0	20,942	
G - RECLASS CENTRAL SERVICE COST					
1.00	ADULTS & PEDIATRICS	30.00	3	1	1.00
2.00	OPERATING ROOM	50.00	77,178	22,494	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	1,222	356	3.00
4.00	CT SCAN	57.00	231	68	4.00
5.00	CARDIAC CATHETERIZATION	59.00	58,767	17,129	5.00
6.00	RESPIRATORY THERAPY	65.00	27,408	7,989	6.00
7.00	PHYSICAL THERAPY	66.00	7,632	2,224	7.00
8.00	SPEECH PATHOLOGY	68.00	1,494	435	8.00
	O		173,935	50,696	
I - RECLASS PLANT OPERATIONS					
1.00	OPERATION OF PLANT	7.00	433,866	1,449,621	1.00
	O		433,866	1,449,621	
J - RECLASS O/S PRINTING TO NON-REIMBURS					
1.00	OUTSIDE PRINTING	193.07	32,996	35,389	1.00
	O		32,996	35,389	
L - RECLASS UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	319,668	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
	O		0	319,668	
M - RECLASS REAL ESTATE TAXES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	114,676	1.00
3.00		0.00	0	0	3.00
	O		0	114,676	
N - RECLASS HYPERBARIC OXYGEN THERAPY					
1.00	HYPERBARIC OXYGEN THERAPY	65.98	53,005	7,661	1.00
	O		53,005	7,661	
O - BUILDING INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	118,382	1.00
2.00		0.00	0	0	2.00
	O		0	118,382	
P - C. SUPPLIES - CHARGEABLE IMPLANTABLE					
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	690,075	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	690,075	
Q - C. SUPPLIES-CHARGEABLE MED SUPPLIES					
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	2,506,749	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

RECLASSIFICATIONS

Provider CCN: 140034

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

Worksheet A-6

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						Increases			
Cost Center		Line #	Salary	Other					
2.00		3.00	4.00	5.00					
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	
TOTALS			0	2,506,749					
R - PHARM-DRUGS CHARGED TO PATIENTS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,766,641				1.00	
TOTALS			0	3,766,641					
500.00	Grand Total: Increases		1,840,342	9,641,306				500.00	

RECLASSIFICATIONS

Provider CCN: 140034

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

Worksheet A-6
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Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - RECLASS FROM OB TO NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	347,114	49,899	0		1.00
	O		347,114	49,899			
B - RECLASS FROM OB TO DELIVERY ROOM							
1.00	ADULTS & PEDIATRICS	30.00	269,174	38,695	0		1.00
	O		269,174	38,695			
C - RECLASS FROM DIETARY TO CAFETERIA							
1.00	DIETARY	10.00	530,252	472,212	0		1.00
	O		530,252	472,212			
F - INVENTORY COST TO CENTRAL SERVICES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,942	0		1.00
	TOTALS		0	20,942			
G - RECLASS CENTRAL SERVICE COST							
1.00	CENTRAL SERVICE & SUPPLY	14.00	173,935	50,696	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	O		173,935	50,696			
I - RECLASS PLANT OPERATIONS							
1.00	MAINTENANCE & REPAIRS	6.00	433,866	1,449,621	0		1.00
	O		433,866	1,449,621			
J - RECLASS O/S PRINTING TO NON-REIMBURS							
1.00	ADMINISTRATIVE & GENERAL	5.00	32,996	35,389	0		1.00
	O		32,996	35,389			
L - RECLASS UTILITIES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	114,912	0		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	0	1,212	0		2.00
3.00	HOUSEKEEPING	9.00	0	124,517	0		3.00
4.00	DIETARY	10.00	0	67	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,712	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	211	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	38	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	6,212	0		8.00
9.00	SPEECH PATHOLOGY	68.00	0	135	0		9.00
10.00	CLINIC	90.00	0	27	0		10.00
11.00	PSYCH SERVICES	90.02	0	1,226	0		11.00
12.00	OTHER NON-REIMBURSABLE	193.05	0	69,399	0		12.00
	O		0	319,668			
M - RECLASS REAL ESTATE TAXES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,056	13		1.00
3.00	OTHER NON-REIMBURSABLE	193.05	0	110,620	13		3.00
	O		0	114,676			
N - RECLASS HYPERBARIC OXYGEN THERAPY							
1.00	CLINIC	90.00	53,005	7,661	0		1.00
	O		53,005	7,661			
O - BUILDING INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	117,795	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	587	0		2.00
	O		0	118,382			
P - C. SUPPLIES - CHARGEABLE IMPLANTABLE							
1.00	OPERATING ROOM	50.00	0	599,683	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	35	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	90,357	0		3.00
	TOTALS		0	690,075			
Q - C. SUPPLIES-CHARGEABLE MED SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	465,393	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	150,804	0		2.00
3.00	SUBPROVIDER - IPF	40.00	0	8,529	0		3.00
4.00	OPERATING ROOM	50.00	0	1,048,313	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	101,615	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	38,882	0		6.00
7.00	CARDIAC REHABILITATION	54.01	0	397	0		7.00
8.00	NUCLEAR MEDICINE	56.01	0	3,106	0		8.00
9.00	CT SCAN	57.00	0	38,275	0		9.00
10.00	MRI	58.00	0	28,516	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	68,572	0		11.00
12.00	LABORATORY	60.00	0	62,763	0		12.00
13.00	INTRAVENOUS THERAPY	64.00	0	47,467	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	30,570	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	10,543	0		15.00

Provider CCN: 140034

Period:
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Worksheet A-6
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Decreases								
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
16.00	SPEECH PATHOLOGY	68.00	0	27	0		16.00	
17.00	ELECTROCARDIOLOGY	69.00	0	14,785	0		17.00	
18.00	NEUROLOGY	70.01	0	15,470	0		18.00	
19.00	CLINIC	90.00	0	50,262	0		19.00	
20.00	PSYCH SERVICES	90.02	0	118	0		20.00	
21.00	EMERGENCY	91.00	0	318,075	0		21.00	
22.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4,267	0		22.00	
	TOTALS		0	2,506,749				
R - PHARM-DRUGS CHARGED TO PATIENTS								
1.00	PHARMACY	15.00	0	3,766,641	0		1.00	
	TOTALS		0	3,766,641				
500.00	Grand Total: Decreases		1,840,342	9,641,306			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140034

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

Worksheet A-7
Part I
Date/Time Prepared:
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		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,259,000	0	0	0	0	1.00
2.00	Land Improvements	667,526	0	0	0	0	2.00
3.00	Buildings and Fixtures	27,639,835	1,404,079	0	1,404,079	214,825	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,049,540	466,338	0	466,338	1,518	5.00
6.00	Movable Equipment	18,994,126	2,319,632	0	2,319,632	549,069	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	50,610,027	4,190,049	0	4,190,049	765,412	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	50,610,027	4,190,049	0	4,190,049	765,412	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,259,000	0				1.00
2.00	Land Improvements	667,526	0				2.00
3.00	Buildings and Fixtures	28,829,089	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	2,514,360	0				5.00
6.00	Movable Equipment	20,764,689	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	54,034,664	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	54,034,664	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140034

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

Worksheet A-7
Part II
Date/Time Prepared:
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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	1,575,216	0	1,114	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,085,923	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,661,139	0	1,114	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	1,576,330				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,085,923				2.00
3.00	Total (sum of lines 1-2)	0	3,662,253				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140034

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

Worksheet A-7
Part III
Date/Time Prepared:
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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	29,078,835	0	29,078,835	0.583402	69,064	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	20,764,689	0	20,764,689	0.416598	49,318	2.00
3.00	Total (sum of lines 1-2)	49,843,524	0	49,843,524	1.000000	118,382	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	69,064	2,029,481	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	49,318	2,693,985	0	2.00
3.00	Total (sum of lines 1-2)	0	0	118,382	4,723,466	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	1,114	69,064	114,676	0	2,214,335	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	289,199	49,318	0	0	3,032,502	2.00
3.00	Total (sum of lines 1-2)	290,313	118,382	114,676	0	5,246,837	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140034

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

Worksheet A-8

Date/Time Prepared:
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			3.00	4.00			
1.00	2.00	3.00	4.00	5.00			
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	415,783		ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-14,527		ADMINISTRATIVE & GENERAL	5.00	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	-4,311,911				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	-10,607,811				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-89,728		DIETARY	10.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	A	-1,847		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	328,026		CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	70,257		CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00 Non-physician Anesthetist	A	-189,955		NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	0	33.00

Provider CCN: 140034

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

Worksheet A-8

Date/Time Prepared:
 5/30/2016 11:51 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
34.00	MI SC. REVENUE	B	-10	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 34.00
35.00			0		0.00	0 35.00
35.02	MI SC. REVENUE	B	-130	HOUSEKEEPING	9.00	0 35.02
37.00			0		0.00	0 37.00
38.00			0		0.00	0 38.00
39.00	MI SC. REVENUE	B	-144,939	RADIOLOGY-DIAGNOSTIC	54.00	0 39.00
40.00	GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-472	OPERATING ROOM	50.00	0 40.00
41.01	MI SC. REVENUE	B	-3,442	RESPIRATORY THERAPY	65.00	0 41.01
42.00	MI SC. REVENUE	B	-18,994	PHYSICAL THERAPY	66.00	0 42.00
44.00	MI SC. REVENUE	B	-230,084	CAFETERIA	11.00	0 44.00
44.01	MI SC. REVENUE	B	-4,893	MAINTENANCE & REPAIRS	6.00	0 44.01
44.02			0		0.00	0 44.02
44.03	MI SC. REVENUE	B	-12,912	CARDIAC REHABILITATION	54.01	0 44.03
45.00	MI SC. REVENUE	B	-215	MEDICAL RECORDS & LIBRARY	16.00	0 45.00
45.01	GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-9,689	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 45.01
45.02	GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-23,582	ADMINISTRATIVE & GENERAL	5.00	0 45.02
45.03	GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-907	MAINTENANCE & REPAIRS	6.00	0 45.03
45.04	MI SC. REVENUE	B	-20	INTENSIVE CARE UNIT	31.00	0 45.04
45.05			0		0.00	0 45.05
45.06	GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-728	NURSING ADMINISTRATION	13.00	0 45.06
45.07			0		0.00	0 45.07
45.08			0		0.00	0 45.08
45.09	GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-1,365	ADULTS & PEDIATRICS	30.00	0 45.09
45.10	GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-142	INTENSIVE CARE UNIT	31.00	0 45.10
45.11	GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-6	SUBPROVIDER - I/PF	40.00	0 45.11
45.12	AMORTIZATION OF GOODWILL	A	-140,151	CAP REL COSTS-MVBLE EQUIP	2.00	9 45.12
45.13	GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-217	PHYSICAL THERAPY	66.00	0 45.13
45.14			0		0.00	0 45.14
45.15	GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-513	LABORATORY	60.00	0 45.15
45.16	PATIENT TELEPHONE SERVICE	A	-17,761	ADMINISTRATIVE & GENERAL	5.00	0 45.16
45.17	PATIENT TELEPHONE SERVICE	A	-29	CAP REL COSTS-BLDG & FIXT	1.00	9 45.17
45.18	PERSONAL USE (AUTO)	A	-750	CAP REL COSTS-MVBLE EQUIP	2.00	9 45.18
45.21	GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-919	EMERGENCY	91.00	0 45.21
45.25	PHYSICIAN RECRUITMENT	A	-173,854	ADMINISTRATIVE & GENERAL	5.00	0 45.25
45.26	GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-99	HOUSEKEEPING	9.00	0 45.26
45.27	GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-190	CLINIC	90.00	0 45.27
45.28			0		0.00	0 45.28
45.29	PATIENT TELEPHONE SERVICE	A	-42	CAP REL COSTS-MVBLE EQUIP	2.00	9 45.29
45.30	PATIENT TELEPHONE SERVICE BENEF	A	-6,423	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 45.30
45.31	MEDICAL RECORDS BENEFITS	A	-492	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 45.31
45.32	PROF LAB INS DEDUCTIBLE RESERV	A	10,000	ADMINISTRATIVE & GENERAL	5.00	0 45.32
45.35			0		0.00	0 45.35
45.36			0		0.00	0 45.36
45.37			0		0.00	0 45.37
45.38	CRNA FEES	A	-5,627	ANESTHESIOLOGY	53.00	0 45.38
45.39	CRNA BENEFITS	A	-83,989	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 45.39
45.40	WSI RENT EXPENSE	A	-49,593	PHYSICAL THERAPY	66.00	0 45.40
45.41			0		0.00	0 45.41
45.43			0		0.00	0 45.43
45.46	DUES RELATED TO LOBBYING EXP.	A	-3,798	ADMINISTRATIVE & GENERAL	5.00	0 45.46
46.00			0		0.00	0 46.00
47.00			0		0.00	0 47.00
48.00			0		0.00	0 48.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140034

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

Worksheet A-8

Date/Time Prepared:
5/30/2016 11:51 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,328,690				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: 140034

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

Worksheet A-8-1

Date/Time Prepared:
5/30/2016 11:51 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	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	127,382	1,114	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	678,748	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE - INTEREST	289,199	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	7,480,424	11,785,266	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	7,241,321	14,140,314	4.01
4.02	6.01	BIOMEDICAL SERVICES	HOME OFFICE	0	452,000	4.02
4.03	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-46,191	0	4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			15,770,883	26,378,694	5.00

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

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

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

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

6.00	B	0.00	MOTHERHOUSE	0.00	6.00
7.00	B	0.00	SSM	0.00	7.00
8.00	B	0.00	FSI	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: 140034

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

Worksheet A-8-1

Date/Time Prepared:
5/30/2016 11:51 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	126,268	9		1.00
2.00	678,748	9		2.00
3.00	289,199	11		3.00
4.00	-4,304,842	0		4.00
4.01	-6,898,993	0		4.01
4.02	-452,000	0		4.02
4.03	-46,191	0		4.03
5.00	-10,607,811			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	CONVENT		6.00
7.00	CORPORATE		7.00
8.00	CORPORATE		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: 140034

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2016 11:51 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	5.00	ADMINISTRATIVE & GENERAL	237,089	258	236,831	211,500	1,744	1.00
2.00	40.00	SUBPROVIDER - IPF	19,000	0	19,000	181,300	204	2.00
3.00	50.00	OPERATING ROOM	51,200	0	51,200	246,400	229	3.00
4.00	53.00	ANESTHESIOLOGY	1,424,897	1,371,496	53,400	239,400	297	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	795,651	775,901	19,750	271,900	79	5.00
6.00	54.01	CARDIAC REHABILITATION	17,002	0	17,002	197,500	76	6.00
7.00	56.01	NUCLEAR MEDICINE	24,452	24,452	0	271,900	0	7.00
8.00	59.00	CARDIAC CATHETERIZATION	24,621	0	24,621	197,500	98	8.00
9.00	60.00	LABORATORY	517,366	476,960	40,406	260,300	227	9.00
10.00	65.00	RESPIRATORY THERAPY	43,129	22,556	20,572	179,000	157	10.00
11.00	66.00	PHYSICAL THERAPY	57,780	57,780	0	179,000	0	11.00
12.00	69.00	ELECTROCARDIOLOGY	365,516	345,906	19,610	179,000	87	12.00
13.00	70.01	NEUROLOGY	270,905	250,505	20,400	179,000	120	13.00
14.00	91.00	EMERGENCY	806,311	806,311	0	179,000	0	14.00
200.00			4,654,919	4,132,125	522,792		3,318	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	5.00	ADMINISTRATIVE & GENERAL	177,335	8,867	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	17,781	889	0	0	0	2.00
3.00	50.00	OPERATING ROOM	27,128	1,356	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	34,183	1,709	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	10,327	516	0	0	0	5.00
6.00	54.01	CARDIAC REHABILITATION	7,216	361	0	0	0	6.00
7.00	56.01	NUCLEAR MEDICINE	0	0	0	0	0	7.00
8.00	59.00	CARDIAC CATHETERIZATION	9,305	465	0	0	0	8.00
9.00	60.00	LABORATORY	28,408	1,420	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	13,511	676	0	0	0	10.00
11.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	11.00
12.00	69.00	ELECTROCARDIOLOGY	7,487	374	0	0	0	12.00
13.00	70.01	NEUROLOGY	10,327	516	0	0	0	13.00
14.00	91.00	EMERGENCY	0	0	0	0	0	14.00
200.00			343,008	17,149	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	5.00	ADMINISTRATIVE & GENERAL	0	177,335	59,496	59,754		1.00
2.00	40.00	SUBPROVIDER - IPF	0	17,781	1,219	1,219		2.00
3.00	50.00	OPERATING ROOM	0	27,128	24,072	24,072		3.00
4.00	53.00	ANESTHESIOLOGY	0	34,183	19,217	1,390,714		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	10,327	9,423	785,324		5.00
6.00	54.01	CARDIAC REHABILITATION	0	7,216	9,786	9,786		6.00
7.00	56.01	NUCLEAR MEDICINE	0	0	0	24,452		7.00
8.00	59.00	CARDIAC CATHETERIZATION	0	9,305	15,316	15,316		8.00
9.00	60.00	LABORATORY	0	28,408	11,998	488,958		9.00
10.00	65.00	RESPIRATORY THERAPY	0	13,511	7,061	29,618		10.00
11.00	66.00	PHYSICAL THERAPY	0	0	0	57,780		11.00
12.00	69.00	ELECTROCARDIOLOGY	0	7,487	12,123	358,029		12.00
13.00	70.01	NEUROLOGY	0	10,327	10,073	260,578		13.00
14.00	91.00	EMERGENCY	0	0	0	806,311		14.00
200.00			0	343,008	179,784	4,311,911		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140034

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2016 11:51 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	2,214,335	2,214,335			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	3,032,502		3,032,502		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	9,066,563	12,099	0	9,078,662	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	17,814,144	695,458	462,775	1,105,325	5.00
6.00 00600	MAINTENANCE & REPAIRS	1,301,192	45,325	0	114,936	6.00
6.01 00601	BIOMEDICAL SERVICES	589,658	5,582	0	0	6.01
7.00 00700	OPERATION OF PLANT	2,203,155	116,661	123,796	128,452	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	355,340	39,464	1,838	32,691	8.00
9.00 00900	HOUSEKEEPING	1,182,270	28,812	8,659	298,939	9.00
10.00 01000	DIETARY	426,066	16,399	6,957	98,065	10.00
11.00 01100	CAFETERIA	772,380	42,043	17,840	156,989	11.00
13.00 01300	NURSING ADMINISTRATION	717,140	4,135	305,331	193,199	13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	2,506,749	0	0	0	14.00
15.00 01500	PHARMACY	1,370,279	0	10,495	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	913,367	33,319	2,892	172,175	16.00
17.00 01700	SOCIAL SERVICE	9,734	4,238	0	2,840	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5,881,001	289,220	175,545	1,678,493	30.00
31.00 03100	INTENSIVE CARE UNIT	2,578,542	29,970	214,712	571,952	31.00
40.00 04000	SUBPROVIDER - I/PF	1,050,950	37,025	0	292,306	40.00
43.00 04300	NURSERY	397,013	20,104	25,158	102,768	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,853,141	236,179	476,213	595,346	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	307,869	34,120	19,509	79,693	52.00
53.00 05300	ANESTHESIOLOGY	73,904	2,150	14,134	4	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,504,329	69,315	586,275	448,297	54.00
54.01 05401	CARDIAC REHABILITATION	81,756	0	8,121	19,805	54.01
56.01 03470	NUCLEAR MEDICINE	590,286	4,879	28,188	47,131	56.01
57.00 05700	CT SCAN	321,506	3,623	134,684	86,475	57.00
58.00 05800	MRI	175,209	2,109	5,398	46,659	58.00
59.00 05900	CARDIAC CATHETERIZATION	290,774	13,236	13,251	84,084	59.00
60.00 06000	LABORATORY	3,571,169	37,056	106,275	406,983	60.00
64.00 06400	INTRAVENOUS THERAPY	293,228	5,483	1,385	83,212	64.00
65.00 06500	RESPIRATORY THERAPY	785,207	5,396	45,520	204,782	65.00
65.98 06501	HYPERBARIC OXYGEN THERAPY	60,666	1,070	18,341	15,693	65.98
66.00 06600	PHYSICAL THERAPY	1,379,676	24,606	14,409	385,004	66.00
68.00 06800	SPEECH PATHOLOGY	112,477	3,737	2,582	32,361	68.00
69.00 06900	ELECTROCARDIOLOGY	636,090	31,004	105,820	192,977	69.00
70.01 07001	NEUROLOGY	320,149	11,396	8,342	89,216	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	-46,191	0	0	0	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	690,075	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	3,766,641	0	0	335,446	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	316,044	1,850	18,547	81,281	90.00
90.01 09002	DIABETES EDUCATION	23,135	331	0	6,735	90.01
90.02 09001	PSYCH SERVICES	266,947	54,157	871	75,403	90.02
90.04 09003	ANTI COAGULATION CLINIC	133,641	517	0	39,437	90.04
91.00 09100	EMERGENCY	2,410,668	30,740	35,776	671,507	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	75,300,776	1,992,808	2,999,639	8,976,661	74,944,385
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	19,862	1,695	0	5,628	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	548,340	0	2,017	20,719	192.00
193.05 19305	OTHER NON-REIMBURSABLE	318,949	219,832	17,561	32,900	193.05
193.06 19306	OUTSIDE ACCOUNTING	0	0	0	0	193.06
193.07 19307	OUTSIDE PRINTING	68,385	0	13,285	9,769	193.07
193.08 19308	FOUNDATION	0	0	0	32,985	193.08
194.00 07951	AHEC	0	0	0	0	194.00
194.01 07950	OTHER NONREIMBURSABLE COST CENTERS	6,000	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140034

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2016 11:51 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		201.00
202.00 TOTAL (sum lines 118-201)	76,262,312	2,214,335	3,032,502	9,078,662	76,262,312	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part I Date/Time Prepared: 5/30/2016 11:51 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	BIOMEDICAL SERVICES	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE		
		5.00	6.00	6.01	7.00	8.00		
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	20,077,702				5.00	
6.00	00600	MAINTENANCE & REPAIRS	521,825	1,983,278			6.00	
6.01	00601	BIOMEDICAL SERVICES	212,536	3,724	811,500		6.01	
7.00	00700	OPERATION OF PLANT	918,379	11,848	0	3,502,291	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	153,297	78,194	0	103,206	764,030	8.00
9.00	00900	HOUSEKEEPING	542,258	15,233	0	75,350	45,628	9.00
10.00	01000	DIETARY	195,485	86,656	0	42,885	2,100	10.00
11.00	01100	CAFETERIA	353,221	222,057	0	109,950	5,385	11.00
13.00	01300	NURSING ADMINISTRATION	435,542	10,494	7,106	10,813	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	895,057	60,592	0	0	0	14.00
15.00	01500	PHARMACY	493,018	18,279	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	400,532	0	0	87,136	0	16.00
17.00	01700	SOCIAL SERVICE	6,003	3,385	0	11,083	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,865,123	406,195	274,169	756,367	252,568	30.00
31.00	03100	INTENSIVE CARE UNIT	1,212,278	56,530	38,283	78,378	57,714	31.00
40.00	04000	SUBPROVIDER - I PF	492,842	35,543	37,136	96,827	18,787	40.00
43.00	04300	NURSERY	194,613	54,837	24,070	52,576	3,843	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,485,679	159,773	108,200	617,655	91,420	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	157,531	27,757	18,797	89,231	25,403	52.00
53.00	05300	ANESTHESIOLOGY	32,204	0	0	5,623	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	931,287	120,506	81,379	181,273	68,318	54.00
54.01	05401	CARDIAC REHABILITATION	39,163	0	0	0	0	54.01
56.01	03470	NUCLEAR MEDICINE	239,402	3,724	2,522	12,759	0	56.01
57.00	05700	CT SCAN	195,057	339	229	9,475	0	57.00
58.00	05800	MRI	81,900	0	4,356	5,514	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	143,304	5,755	3,897	34,614	3,692	59.00
60.00	06000	LABORATORY	1,471,613	61,269	41,492	96,908	0	60.00
64.00	06400	INTRAVENOUS THERAPY	136,864	10,494	0	14,340	3,475	64.00
65.00	06500	RESPIRATORY THERAPY	371,664	5,755	3,897	14,110	0	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	34,196	0	0	2,798	0	65.98
66.00	06600	PHYSICAL THERAPY	644,026	23,695	16,047	64,348	38,908	66.00
68.00	06800	SPEECH PATHOLOGY	53,972	2,031	1,375	9,772	0	68.00
69.00	06900	ELECTROCARDIOLOGY	344,880	0	23,611	81,081	9,283	69.00
70.01	07001	NEUROLOGY	153,215	4,401	2,980	29,802	7,810	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	246,397	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,464,687	0	0	0	241	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	149,151	30,804	0	4,839	4,036	90.00
90.01	09002	DIABETES EDUCATION	10,784	0	0	865	0	90.01
90.02	09001	PSYCH SERVICES	141,887	30,127	20,402	141,631	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	61,984	0	0	1,352	0	90.04
91.00	09100	EMERGENCY	1,124,268	145,555	98,572	80,392	106,013	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,607,124	1,695,552	808,520	2,922,953	744,624	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	9,707	0	0	4,433	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	203,908	0	0	0	14,376	192.00
193.05	19305	OTHER NON-REIMBURSABLE	210,394	285,356	2,980	574,905	5,030	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
193.07	19307	OUTSIDE PRINTING	32,649	2,370	0	0	0	193.07
193.08	19308	FOUNDATION	11,778	0	0	0	0	193.08
194.00	07951	AHEC	0	0	0	0	0	194.00
194.01	07950	OTHER NONREIMBURSABLE COST CENTERS	2,142	0	0	0	0	194.01
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)	20,077,702	1,983,278	811,500	3,502,291	764,030	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part I Date/Time Prepared: 5/30/2016 11:51 am	
Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	BIOMEDICAL SERVICES						6.01
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	2,197,149					9.00
10.00	01000	DIETARY	3,496	878,109				10.00
11.00	01100	CAFETERIA	8,545	0	1,688,410			11.00
13.00	01300	NURSING ADMINISTRATION	1,165	0	37,437	1,722,362		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	3,462,398	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,808	0	56,156	58,584	0	16.00
17.00	01700	SOCIAL SERVICE	8,156	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	3,744	3,906	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	589,195	614,979	449,244	468,670	0	30.00
31.00	03100	INTENSIVE CARE UNIT	102,148	67,119	123,542	128,884	0	31.00
40.00	04000	SUBPROVIDER - IPF	144,094	107,178	71,130	74,206	0	40.00
43.00	04300	NURSERY	25,634	0	18,719	19,528	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	238,863	15,658	146,004	152,318	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,964	0	26,206	27,339	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	60,201	15,200	97,336	101,545	0	54.00
54.01	05401	CARDIAC REHABILITATION	25,246	0	7,487	7,811	0	54.01
56.01	03470	NUCLEAR MEDICINE	6,214	0	7,487	7,811	0	56.01
57.00	05700	CT SCAN	10,487	0	18,719	19,528	0	57.00
58.00	05800	MRI	10,098	0	11,231	11,717	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	29,518	2,473	18,719	19,528	0	59.00
60.00	06000	LABORATORY	49,326	0	131,030	136,695	0	60.00
64.00	06400	INTRAVENOUS THERAPY	25,634	3,369	18,719	19,528	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,884	0	59,899	62,489	0	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	9,321	0	3,744	3,906	0	65.98
66.00	06600	PHYSICAL THERAPY	58,648	0	86,105	89,828	0	66.00
68.00	06800	SPEECH PATHOLOGY	3,884	0	7,487	7,811	0	68.00
69.00	06900	ELECTROCARDIOLOGY	33,402	4,547	44,924	46,867	0	69.00
70.01	07001	NEUROLOGY	13,594	2,181	22,462	23,433	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	2,718,671	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	743,727	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	40,781	1,305	22,462	23,433	0	90.00
90.01	09002	DIABETES EDUCATION	0	0	3,744	3,906	0	90.01
90.02	09001	PSYCH SERVICES	101,371	0	18,719	19,528	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	3,496	0	3,744	3,906	0	90.04
91.00	09100	EMERGENCY	234,979	44,100	149,748	156,223	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,889,152	878,109	1,665,948	1,698,928	3,462,398	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	3,744	3,906	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	85,447	0	7,487	7,811	0	192.00
193.05	19305	OTHER NON-REIMBURSABLE	222,550	0	7,487	7,811	0	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
193.07	19307	OUTSIDE PRINTING	0	0	3,744	3,906	0	193.07
193.08	19308	FOUNDATION	0	0	0	0	0	193.08
194.00	07951	AHEC	0	0	0	0	0	194.00
194.01	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,197,149	878,109	1,688,410	1,722,362	3,462,398	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part I Date/Time Prepared: 5/30/2016 11:51 am				
Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal		
		15.00	16.00	17.00	19.00	24.00		
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		
6.01	00601	BIOMEDICAL SERVICES				6.01		
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 SERVICE & SUPPLY				14.00		
15.00	01500	PHARMACY	1,892,071			15.00		
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,743,969		16.00		
17.00	01700	SOCIAL SERVICE	0	0	45,439	17.00		
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	7,650	19.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	453,432	32,262	0	15,186,463	30.00
31.00	03100	INTENSIVE CARE UNIT	0	87,198	6,361	0	5,353,611	31.00
40.00	04000	SUBPROVIDER - IPF	0	87,198	6,816	0	2,552,038	40.00
43.00	04300	NURSERY	0	17,440	0	0	956,303	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	139,518	0	0	7,315,967	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	841,419	52.00
53.00	05300	ANESTHESIOLOGY	0	17,440	0	0	145,459	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	122,078	0	0	4,387,339	54.00
54.01	05401	CARDIAC REHABILITATION	0	0	0	0	189,389	54.01
56.01	03470	NUCLEAR MEDICINE	0	34,879	0	0	985,282	56.01
57.00	05700	CT SCAN	0	174,397	0	0	974,519	57.00
58.00	05800	MRI	0	34,879	0	0	389,070	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	17,440	0	0	680,285	59.00
60.00	06000	LABORATORY	0	209,276	0	0	6,319,092	60.00
64.00	06400	INTRAVENOUS THERAPY	0	17,440	0	0	633,171	64.00
65.00	06500	RESPIRATORY THERAPY	0	17,440	0	0	1,580,043	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	0	0	0	0	149,735	65.98
66.00	06600	PHYSICAL THERAPY	0	34,879	0	0	2,860,179	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	237,489	68.00
69.00	06900	ELECTROCARDIOLOGY	0	52,319	0	0	1,606,805	69.00
70.01	07001	NEUROLOGY	0	17,440	0	0	706,421	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	6,007	2,678,487	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	1,643	1,681,842	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,892,071	87,198	0	0	7,546,284	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	17,440	0	0	711,973	90.00
90.01	09002	DIABETES EDUCATION	0	0	0	0	49,500	90.01
90.02	09001	PSYCH SERVICES	0	0	0	0	871,043	90.02
90.04	09003	ANTI COAGULATION CLINIC	0	0	0	0	248,077	90.04
91.00	09100	EMERGENCY	0	104,638	0	0	5,393,179	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,892,071	1,743,969	45,439	7,650	73,230,464	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	48,975	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	890,105	192.00
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	1,905,755	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
193.07	19307	OUTSIDE PRINTING	0	0	0	0	134,108	193.07
193.08	19308	FOUNDATION	0	0	0	0	44,763	193.08
194.00	07951	AHEC	0	0	0	0	0	194.00
194.01	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	8,142	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,892,071	1,743,969	45,439	7,650	76,262,312	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140034

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2016 11:51 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		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
6.01	00601	BIOMEDICAL SERVICES		6.01
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 SERVICE & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	15,186,463
31.00	03100	INTENSIVE CARE UNIT	0	5,353,611
40.00	04000	SUBPROVIDER - IPF	0	2,552,038
43.00	04300	NURSERY	0	956,303
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	7,315,967
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	841,419
53.00	05300	ANESTHESIOLOGY	0	145,459
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,387,339
54.01	05401	CARDIAC REHABILITATION	0	189,389
56.01	03470	NUCLEAR MEDICINE	0	985,282
57.00	05700	CT SCAN	0	974,519
58.00	05800	MRI	0	389,070
59.00	05900	CARDIAC CATHETERIZATION	0	680,285
60.00	06000	LABORATORY	0	6,319,092
64.00	06400	INTRAVENOUS THERAPY	0	633,171
65.00	06500	RESPIRATORY THERAPY	0	1,580,043
65.98	06501	HYPERBARIC OXYGEN THERAPY	0	149,735
66.00	06600	PHYSICAL THERAPY	0	2,860,179
68.00	06800	SPEECH PATHOLOGY	0	237,489
69.00	06900	ELECTROCARDIOLOGY	0	1,606,805
70.01	07001	NEUROLOGY	0	706,421
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	2,678,487
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	1,681,842
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,546,284
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	711,973
90.01	09002	DIABETES EDUCATION	0	49,500
90.02	09001	PSYCH SERVICES	0	871,043
90.04	09003	ANTI COAGULATION CLINIC	0	248,077
91.00	09100	EMERGENCY	0	5,393,179
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	73,230,464
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	48,975
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	890,105
193.05	19305	OTHER NON-REIMBURSABLE	0	1,905,755
193.06	19306	OUTSIDE ACCOUNTING	0	0
193.07	19307	OUTSIDE PRINTING	0	134,108
193.08	19308	FOUNDATION	0	44,763
194.00	07951	AHEC	0	0
194.01	07950	OTHER NONREIMBURSABLE COST CENTERS	0	8,142
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	76,262,312

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/30/2016 11:51 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	150	12,099	0	12,249	12,249 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,488	695,458	462,775	1,160,721	1,490 5.00
6.00 00600	MAINTENANCE & REPAIRS	4,350	45,325	0	49,675	155 6.00
6.01 00601	BIOMEDICAL SERVICES	0	5,582	0	5,582	0 6.01
7.00 00700	OPERATION OF PLANT	0	116,661	123,796	240,457	173 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	174	39,464	1,838	41,476	44 8.00
9.00 00900	HOUSEKEEPING	42,271	28,812	8,659	79,742	403 9.00
10.00 01000	DIETARY	0	16,399	6,957	23,356	132 10.00
11.00 01100	CAFETERIA	0	42,043	17,840	59,883	212 11.00
13.00 01300	NURSING ADMINISTRATION	0	4,135	305,331	309,466	260 13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	15,708	0	0	15,708	0 14.00
15.00 01500	PHARMACY	103,145	0	10,495	113,640	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	33,319	2,892	36,211	232 16.00
17.00 01700	SOCIAL SERVICE	0	4,238	0	4,238	4 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	66,349	289,220	175,545	531,114	2,276 30.00
31.00 03100	INTENSIVE CARE UNIT	1,700	29,970	214,712	246,382	771 31.00
40.00 04000	SUBPROVIDER - IPF	0	37,025	0	37,025	394 40.00
43.00 04300	NURSERY	0	20,104	25,158	45,262	138 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	69,710	236,179	476,213	782,102	802 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	34,120	19,509	53,629	107 52.00
53.00 05300	ANESTHESIOLOGY	2,688	2,150	14,134	18,972	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	18,596	69,315	586,275	674,186	604 54.00
54.01 05401	CARDIAC REHABILITATION	0	0	8,121	8,121	27 54.01
56.01 03470	NUCLEAR MEDICINE	0	4,879	28,188	33,067	64 56.01
57.00 05700	CT SCAN	8	3,623	134,684	138,315	117 57.00
58.00 05800	MRI	9,376	2,109	5,398	16,883	63 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	13,236	13,251	26,487	113 59.00
60.00 06000	LABORATORY	90,416	37,056	106,275	233,747	548 60.00
64.00 06400	INTRAVENOUS THERAPY	0	5,483	1,385	6,868	112 64.00
65.00 06500	RESPIRATORY THERAPY	7,202	5,396	45,520	58,118	276 65.00
65.98 06501	HYPERBARIC OXYGEN THERAPY	0	1,070	18,341	19,411	21 65.98
66.00 06600	PHYSICAL THERAPY	84,007	24,606	14,409	123,022	519 66.00
68.00 06800	SPEECH PATHOLOGY	0	3,737	2,582	6,319	44 68.00
69.00 06900	ELECTROCARDIOLOGY	224	31,004	105,820	137,048	260 69.00
70.01 07001	NEUROLOGY	621	11,396	8,342	20,359	120 70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0 71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	452 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	1,850	18,547	20,397	110 90.00
90.01 09002	DIABETES EDUCATION	0	331	0	331	9 90.01
90.02 09001	PSYCH SERVICES	315	54,157	871	55,343	102 90.02
90.04 09003	ANTI COAGULATION CLINIC	0	517	0	517	53 90.04
91.00 09100	EMERGENCY	0	30,740	35,776	66,516	905 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0 99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	519,498	1,992,808	2,999,639	5,511,945	12,112 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	1,695	0	1,695	8 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	11,110	0	2,017	13,127	28 192.00
193.05 19305	OTHER NON-REIMBURSABLE	199,107	219,832	17,561	436,500	44 193.05
193.06 19306	OUTSIDE ACCOUNTING	0	0	0	0	0 193.06
193.07 19307	OUTSIDE PRINTING	0	0	13,285	13,285	13 193.07
193.08 19308	FOUNDATION	5,389	0	0	5,389	44 193.08
194.00 07951	AHEC	0	0	0	0	0 194.00
194.01 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 5/30/2016 11:51 am	
		CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT		
Cost Center Description		Directly Assigned New Capital Related Costs	BLDG & FIXT				MVBLE EQUIP
202.00	TOTAL (sum lines 118-201)	735,104	2,214,335	3,032,502	5,981,941	12,249	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/30/2016 11:51 am				
Cost Center	Description	ADMINISTRATIVE & GENERAL 5.00	MAINTENANCE & REPAIRS 6.00	BIOMEDICAL SERVICES 6.01	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00		
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	1,162,211				5.00	
6.00	00600	MAINTENANCE & REPAIRS	30,207	80,037			6.00	
6.01	00601	BIOMEDICAL SERVICES	12,303	150	18,035		6.01	
7.00	00700	OPERATION OF PLANT	53,162	478	0	294,270	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	8,874	3,156	0	8,672	62,222	8.00
9.00	00900	HOUSEKEEPING	31,390	615	0	6,331	3,716	9.00
10.00	01000	DIETARY	11,316	3,497	0	3,603	171	10.00
11.00	01100	CAFETERIA	20,447	8,961	0	9,238	439	11.00
13.00	01300	NURSING ADMINISTRATION	25,212	423	158	908	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	51,812	2,445	0	0	0	14.00
15.00	01500	PHARMACY	28,539	738	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,186	0	0	7,321	0	16.00
17.00	01700	SOCIAL SERVICE	347	137	0	931	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	165,832	16,393	6,091	63,552	20,566	30.00
31.00	03100	INTENSIVE CARE UNIT	70,175	2,281	851	6,585	4,700	31.00
40.00	04000	SUBPROVIDER - IPF	28,529	1,434	825	8,136	1,530	40.00
43.00	04300	NURSERY	11,265	2,213	535	4,418	313	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	86,001	6,448	2,405	51,897	7,445	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,119	1,120	418	7,497	2,069	52.00
53.00	05300	ANESTHESIOLOGY	1,864	0	0	472	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,909	4,863	1,809	15,231	5,564	54.00
54.01	05401	CARDIAC REHABILITATION	2,267	0	0	0	0	54.01
56.01	03470	NUCLEAR MEDICINE	13,858	150	56	1,072	0	56.01
57.00	05700	CT SCAN	11,291	14	5	796	0	57.00
58.00	05800	MRI	4,741	0	97	463	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	8,295	232	87	2,908	301	59.00
60.00	06000	LABORATORY	85,187	2,473	922	8,142	0	60.00
64.00	06400	INTRAVENOUS THERAPY	7,923	423	0	1,205	283	64.00
65.00	06500	RESPIRATORY THERAPY	21,514	232	87	1,186	0	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	1,979	0	0	235	0	65.98
66.00	06600	PHYSICAL THERAPY	37,281	956	357	5,407	3,169	66.00
68.00	06800	SPEECH PATHOLOGY	3,124	82	31	821	0	68.00
69.00	06900	ELECTROCARDIOLOGY	19,964	0	525	6,813	756	69.00
70.01	07001	NEUROLOGY	8,869	178	66	2,504	636	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	14,263	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	84,786	0	0	0	20	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,634	1,243	0	407	329	90.00
90.01	09002	DIABETES EDUCATION	624	0	0	73	0	90.01
90.02	09001	PSYCH SERVICES	8,213	1,216	453	11,900	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	3,588	0	0	114	0	90.04
91.00	09100	EMERGENCY	65,080	5,874	2,191	6,755	8,634	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,134,970	68,425	17,969	245,593	60,641	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	562	0	0	372	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,804	0	0	0	1,171	192.00
193.05	19305	OTHER NON-REIMBURSABLE	12,179	11,516	66	48,305	410	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
193.07	19307	OUTSIDE PRINTING	1,890	96	0	0	0	193.07
193.08	19308	FOUNDATION	682	0	0	0	0	193.08
194.00	07951	AHEC	0	0	0	0	0	194.00
194.01	07950	OTHER NONREIMBURSABLE COST CENTERS	124	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,162,211	80,037	18,035	294,270	62,222	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/30/2016 11:51 am			
Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
6.01	00601						6.01
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	122,197					9.00
10.00	01000	194	42,269				10.00
11.00	01100	475	0	99,655			11.00
13.00	01300	65	0	2,210	338,702		13.00
14.00	01400	0	0	0	0	69,965	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	1,102	0	3,314	11,520	0	16.00
17.00	01700	454	0	0	0	0	17.00
19.00	01900	0	0	221	768	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	32,768	29,602	26,513	92,166	0	30.00
31.00	03100	5,681	3,231	7,292	25,345	0	31.00
40.00	04000	8,014	5,159	4,198	14,593	0	40.00
43.00	04300	1,426	0	1,105	3,840	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	13,285	754	8,618	29,953	0	50.00
52.00	05200	1,555	0	1,547	5,376	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	3,348	732	5,745	19,969	0	54.00
54.01	05401	1,404	0	442	1,536	0	54.01
56.01	03470	346	0	442	1,536	0	56.01
57.00	05700	583	0	1,105	3,840	0	57.00
58.00	05800	562	0	663	2,304	0	58.00
59.00	05900	1,642	119	1,105	3,840	0	59.00
60.00	06000	2,743	0	7,734	26,881	0	60.00
64.00	06400	1,426	162	1,105	3,840	0	64.00
65.00	06500	216	0	3,535	12,289	0	65.00
65.98	06501	518	0	221	768	0	65.98
66.00	06600	3,262	0	5,082	17,665	0	66.00
68.00	06800	216	0	442	1,536	0	68.00
69.00	06900	1,858	219	2,652	9,216	0	69.00
70.01	07001	756	105	1,326	4,608	0	70.01
71.00	07100	0	0	0	0	54,936	71.00
72.00	07200	0	0	0	0	15,029	72.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	2,268	63	1,326	4,608	0	90.00
90.01	09002	0	0	221	768	0	90.01
90.02	09001	5,638	0	1,105	3,840	0	90.02
90.04	09003	194	0	221	768	0	90.04
91.00	09100	13,069	2,123	8,839	30,721	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		105,068	42,269	98,329	334,094	69,965	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	221	768	0	190.00
192.00	19200	4,752	0	442	1,536	0	192.00
193.05	19305	12,377	0	442	1,536	0	193.05
193.06	19306	0	0	0	0	0	193.06
193.07	19307	0	0	221	768	0	193.07
193.08	19308	0	0	0	0	0	193.08
194.00	07951	0	0	0	0	0	194.00
194.01	07950	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		122,197	42,269	99,655	338,702	69,965	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/30/2016 11:51 am		
Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal
		15.00	16.00	17.00	19.00	24.00
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
6.01	00601	BIOMEDICAL SERVICES				6.01
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 SERVICE & SUPPLY				14.00
15.00	01500	PHARMACY	142,917			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	82,886		16.00
17.00	01700	SOCIAL SERVICE	0	0	6,111	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	989
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	21,549	4,338	1,012,760
31.00	03100	INTENSIVE CARE UNIT	0	4,144	856	378,294
40.00	04000	SUBPROVIDER - IPF	0	4,144	917	114,898
43.00	04300	NURSERY	0	829	0	71,344
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,631	0	996,341
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	82,437
53.00	05300	ANESTHESIOLOGY	0	829	0	22,137
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,802	0	791,762
54.01	05401	CARDIAC REHABILITATION	0	0	0	13,797
56.01	03470	NUCLEAR MEDICINE	0	1,658	0	52,249
57.00	05700	CT SCAN	0	8,289	0	164,355
58.00	05800	MRI	0	1,658	0	27,434
59.00	05900	CARDIAC CATHETERIZATION	0	829	0	45,958
60.00	06000	LABORATORY	0	9,946	0	378,323
64.00	06400	INTRAVENOUS THERAPY	0	829	0	24,176
65.00	06500	RESPIRATORY THERAPY	0	829	0	98,282
65.98	06501	HYPERBARIC OXYGEN THERAPY	0	0	0	23,153
66.00	06600	PHYSICAL THERAPY	0	1,658	0	198,378
68.00	06800	SPEECH PATHOLOGY	0	0	0	12,615
69.00	06900	ELECTROCARDIOLOGY	0	2,487	0	181,798
70.01	07001	NEUROLOGY	0	829	0	40,356
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	54,936
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	29,292
73.00	07300	DRUGS CHARGED TO PATIENTS	142,917	4,144	0	232,319
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	829	0	40,214
90.01	09002	DIABETES EDUCATION	0	0	0	2,026
90.02	09001	PSYCH SERVICES	0	0	0	87,810
90.04	09003	ANTI COAGULATION CLINIC	0	0	0	5,455
91.00	09100	EMERGENCY	0	4,973	0	215,680
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)				
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	142,917	82,886	6,111	0
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	3,626
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	32,860
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	523,375
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0
193.07	19307	OUTSIDE PRINTING	0	0	0	16,273
193.08	19308	FOUNDATION	0	0	0	6,115
194.00	07951	AHEC	0	0	0	0
194.01	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	124
200.00		Cross Foot Adjustments				989
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	142,917	82,886	6,111	989

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/30/2016 11:51 am
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		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
6.01	00601	BIOMEDICAL SERVICES		6.01
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 SERVICE & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
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	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
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
54.01	05401	CARDIAC REHABILITATION	0	54.01
56.01	03470	NUCLEAR MEDICINE	0	56.01
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	0	65.98
66.00	06600	PHYSICAL THERAPY	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.01	07001	NEUROLOGY	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
90.01	09002	DIABETES EDUCATION	0	90.01
90.02	09001	PSYCH SERVICES	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	0	90.04
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	99.40
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.05	19305	OTHER NON-REIMBURSABLE	0	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	193.06
193.07	19307	OUTSIDE PRINTING	0	193.07
193.08	19308	FOUNDATION	0	193.08
194.00	07951	AHEC	0	194.00
194.01	07950	OTHER NONREIMBURSABLE COST CENTERS	0	194.01
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140034

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

Worksheet B-1

Date/Time Prepared:
5/30/2016 11:51 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	428,458				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		1,966,339			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,341	0	30,664,515		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	134,567	300,073	3,733,400	-20,077,702	5.00
6.00 00600	MAINTENANCE & REPAIRS	8,770	0	388,213	0	6.00
6.01 00601	BIOMEDICAL SERVICES	1,080	0	0	0	6.01
7.00 00700	OPERATION OF PLANT	22,573	80,272	433,866	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	7,636	1,192	110,420	0	8.00
9.00 00900	HOUSEKEEPING	5,575	5,615	1,009,712	0	9.00
10.00 01000	DIETARY	3,173	4,511	331,229	0	10.00
11.00 01100	CAFETERIA	8,135	11,568	530,252	0	11.00
13.00 01300	NURSING ADMINISTRATION	800	197,983	652,558	0	13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	6,805	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	6,447	1,875	581,547	0	16.00
17.00 01700	SOCIAL SERVICE	820	0	9,593	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	55,962	113,827	5,669,351	0	30.00
31.00 03100	INTENSIVE CARE UNIT	5,799	139,224	1,931,854	0	31.00
40.00 04000	SUBPROVIDER - I/PF	7,164	0	987,307	0	40.00
43.00 04300	NURSERY	3,890	16,313	347,114	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	45,699	308,787	2,010,869	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	6,602	12,650	269,174	0	52.00
53.00 05300	ANESTHESIOLOGY	416	9,165	13	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	13,412	380,153	1,514,190	0	54.00
54.01 05401	CARDIAC REHABILITATION	0	5,266	66,895	0	54.01
56.01 03470	NUCLEAR MEDICINE	944	18,278	159,192	0	56.01
57.00 05700	CT SCAN	701	87,332	292,081	0	57.00
58.00 05800	MRI	408	3,500	157,597	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	2,561	8,592	284,005	0	59.00
60.00 06000	LABORATORY	7,170	68,911	1,374,647	0	60.00
64.00 06400	INTRAVENOUS THERAPY	1,061	898	281,062	0	64.00
65.00 06500	RESPIRATORY THERAPY	1,044	29,516	691,680	0	65.00
65.98 06501	HYPERBARIC OXYGEN THERAPY	207	11,893	53,005	0	65.98
66.00 06600	PHYSICAL THERAPY	4,761	9,343	1,300,409	0	66.00
68.00 06800	SPEECH PATHOLOGY	723	1,674	109,303	0	68.00
69.00 06900	ELECTROCARDIOLOGY	5,999	68,616	651,808	0	69.00
70.01 07001	NEUROLOGY	2,205	5,409	301,341	0	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	46,191	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	1,133,018	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	358	12,026	274,537	0	90.00
90.01 09002	DIABETES EDUCATION	64	0	22,750	0	90.01
90.02 09001	PSYCH SERVICES	10,479	565	254,684	0	90.02
90.04 09003	ANTI COAGULATION CLINIC	100	0	133,203	0	90.04
91.00 09100	EMERGENCY	5,948	23,198	2,268,116	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	385,594	1,945,030	30,319,995	-20,031,511	54,912,874
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	328	0	19,008	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	1,308	69,980	0	192.00
193.05 19305	OTHER NON-REIMBURSABLE	42,536	11,387	111,125	0	193.05
193.06 19306	OUTSIDE ACCOUNTING	0	0	0	0	193.06
193.07 19307	OUTSIDE PRINTING	0	8,614	32,995	0	193.07
193.08 19308	FOUNDATION	0	0	111,412	0	193.08
194.00 07951	AHEC	0	0	0	0	194.00
194.01 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140034

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

Worksheet B-1

Date/Time Prepared:
5/30/2016 11:51 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,214,335	3,032,502	9,078,662		20,077,702	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5.168150	1.542207	0.296064		0.357059	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			12,249		1,162,211	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000399		0.020669	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140034

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

Worksheet B-1

Date/Time Prepared:
5/30/2016 11:51 am

Cost Center Description		MAINTENANCE & REPAIRS (HOURS OF SERVICE)	BIOMEDICAL SERVICES (HOURS OF SERVICE)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		6.00	6.01	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	5,859					6.00
6.01	00601	11	3,540				6.01
7.00	00700	35	0	259,127			7.00
8.00	00800	231	0	7,636	612,788		8.00
9.00	00900	45	0	5,575	36,596	5,657	9.00
10.00	01000	256	0	3,173	1,684	9	10.00
11.00	01100	656	0	8,135	4,319	22	11.00
13.00	01300	31	31	800	0	3	13.00
14.00	01400	179	0	0	0	0	14.00
15.00	01500	54	0	0	0	0	15.00
16.00	01600	0	0	6,447	0	51	16.00
17.00	01700	10	0	820	0	21	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,200	1,196	55,962	202,575	1,517	30.00
31.00	03100	167	167	5,799	46,289	263	31.00
40.00	04000	105	162	7,164	15,068	371	40.00
43.00	04300	162	105	3,890	3,082	66	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	472	472	45,699	73,323	615	50.00
52.00	05200	82	82	6,602	20,374	72	52.00
53.00	05300	0	0	416	0	0	53.00
54.00	05400	356	355	13,412	54,794	155	54.00
54.01	05401	0	0	0	0	65	54.01
56.01	03470	11	11	944	0	16	56.01
57.00	05700	1	1	701	0	27	57.00
58.00	05800	0	19	408	0	26	58.00
59.00	05900	17	17	2,561	2,961	76	59.00
60.00	06000	181	181	7,170	0	127	60.00
64.00	06400	31	0	1,061	2,787	66	64.00
65.00	06500	17	17	1,044	0	10	65.00
65.98	06501	0	0	207	0	24	65.98
66.00	06600	70	70	4,761	31,206	151	66.00
68.00	06800	6	6	723	0	10	68.00
69.00	06900	0	103	5,999	7,445	86	69.00
70.01	07001	13	13	2,205	6,264	35	70.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	193	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	91	0	358	3,237	105	90.00
90.01	09002	0	0	64	0	0	90.01
90.02	09001	89	89	10,479	0	261	90.02
90.04	09003	0	0	100	0	9	90.04
91.00	09100	430	430	5,948	85,027	605	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		5,009	3,527	216,263	597,224	4,864	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	328	0	0	190.00
192.00	19200	0	0	0	11,530	220	192.00
193.05	19305	843	13	42,536	4,034	573	193.05
193.06	19306	0	0	0	0	0	193.06
193.07	19307	7	0	0	0	0	193.07
193.08	19308	0	0	0	0	0	193.08
194.00	07951	0	0	0	0	0	194.00
194.01	07950	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		1,983,278	811,500	3,502,291	764,030	2,197,149	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140034

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

Worksheet B-1

Date/Time Prepared:
5/30/2016 11:51 am

Cost Center Description		MAINTENANCE & REPAIRS (HOURS OF SERVICE)	BIOMEDICAL SERVICES (HOURS OF SERVICE)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		6.00	6.01	7.00	8.00	9.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	338.501109	229.237288	13.515732	1.246810	388.394732	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	80,037	18,035	294,270	62,222	122,197	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	13.660522	5.094633	1.135621	0.101539	21.601025	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140034

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

Worksheet B-1

Date/Time Prepared:
5/30/2016 11:51 am

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FULL TIME EQUIVALENT)	NURSING ADMINISTRATION (FULL TIME EQUIVALENT)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
6.01	00601						6.01
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	90,180					10.00
11.00	01100	0	451				11.00
13.00	01300	0	10	441			13.00
14.00	01400	0	0	0	3,212,636		14.00
15.00	01500	0	0	0	0	1,747,004	15.00
16.00	01600	0	15	15	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	1	1	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	63,157	120	120	0	0	30.00
31.00	03100	6,893	33	33	0	0	31.00
40.00	04000	11,007	19	19	0	0	40.00
43.00	04300	0	5	5	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,608	39	39	0	0	50.00
52.00	05200	0	7	7	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	1,561	26	26	0	0	54.00
54.01	05401	0	2	2	0	0	54.01
56.01	03470	0	2	2	0	0	56.01
57.00	05700	0	5	5	0	0	57.00
58.00	05800	0	3	3	0	0	58.00
59.00	05900	254	5	5	0	0	59.00
60.00	06000	0	35	35	0	0	60.00
64.00	06400	346	5	5	0	0	64.00
65.00	06500	0	16	16	0	0	65.00
65.98	06501	0	1	1	0	0	65.98
66.00	06600	0	23	23	0	0	66.00
68.00	06800	0	2	2	0	0	68.00
69.00	06900	467	12	12	0	0	69.00
70.01	07001	224	6	6	0	0	70.01
71.00	07100	0	0	0	2,522,558	0	71.00
72.00	07200	0	0	0	690,078	0	72.00
73.00	07300	0	0	0	0	1,747,004	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	134	6	6	0	0	90.00
90.01	09002	0	1	1	0	0	90.01
90.02	09001	0	5	5	0	0	90.02
90.04	09003	0	1	1	0	0	90.04
91.00	09100	4,529	40	40	0	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		90,180	445	435	3,212,636	1,747,004	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	1	1	0	0	190.00
192.00	19200	0	2	2	0	0	192.00
193.05	19305	0	2	2	0	0	193.05
193.06	19306	0	0	0	0	0	193.06
193.07	19307	0	1	1	0	0	193.07
193.08	19308	0	0	0	0	0	193.08
194.00	07951	0	0	0	0	0	194.00
194.01	07950	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140034

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

Worksheet B-1

Date/Time Prepared:
5/30/2016 11:51 am

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FULL TIME EQUIVALENT)	NURSING ADMINISTRATION (FULL TIME EQUIVALENT)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	878,109	1,688,410	1,722,362	3,462,398	1,892,071	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9.737292	3,743.702882	3,905.582766	1.077744	1.083038	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	42,269	99,655	338,702	69,965	142,917	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.468718	220.964523	768.031746	0.021778	0.081807	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140034

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

Worksheet B-1
Date/Time Prepared:
5/30/2016 11:51 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (BLANK)	
		16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
6.01	00601				6.01
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600	100			16.00
17.00	01700	0	100		17.00
19.00	01900	0	0	3,212,636	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	26	71	0	30.00
31.00	03100	5	14	0	31.00
40.00	04000	5	15	0	40.00
43.00	04300	1	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	8	0	0	50.00
52.00	05200	0	0	0	52.00
53.00	05300	1	0	0	53.00
54.00	05400	7	0	0	54.00
54.01	05401	0	0	0	54.01
56.01	03470	2	0	0	56.01
57.00	05700	10	0	0	57.00
58.00	05800	2	0	0	58.00
59.00	05900	1	0	0	59.00
60.00	06000	12	0	0	60.00
64.00	06400	1	0	0	64.00
65.00	06500	1	0	0	65.00
65.98	06501	0	0	0	65.98
66.00	06600	2	0	0	66.00
68.00	06800	0	0	0	68.00
69.00	06900	3	0	0	69.00
70.01	07001	1	0	0	70.01
71.00	07100	0	0	2,522,558	71.00
72.00	07200	0	0	690,078	72.00
73.00	07300	5	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	1	0	0	90.00
90.01	09002	0	0	0	90.01
90.02	09001	0	0	0	90.02
90.04	09003	0	0	0	90.04
91.00	09100	6	0	0	91.00
92.00	09200				92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	0	0	0	99.10
99.20	09920	0	0	0	99.20
99.30	09930	0	0	0	99.30
99.40	09940	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		100	100	3,212,636	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
192.00	19200	0	0	0	192.00
193.05	19305	0	0	0	193.05
193.06	19306	0	0	0	193.06
193.07	19307	0	0	0	193.07
193.08	19308	0	0	0	193.08
194.00	07951	0	0	0	194.00
194.01	07950	0	0	0	194.01
200.00					200.00
201.00					201.00
202.00		1,743,969	45,439	7,650	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140034

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

Worksheet B-1

Date/Time Prepared:
5/30/2016 11:51 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (BLANK)	
		16.00	17.00	19.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	17,439.690000	454.390000	0.002381	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	82,886	6,111	989	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	828.860000	61.110000	0.000308	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 5/30/2016 11:51 am	
		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	15,186,463		15,186,463	0	15,186,463	30.00
31.00	03100 INTENSIVE CARE UNIT	5,353,611		5,353,611	0	5,353,611	31.00
40.00	04000 SUBPROVIDER - I/PF	2,552,038		2,552,038	1,219	2,553,257	40.00
43.00	04300 NURSERY	956,303		956,303	0	956,303	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	7,315,967		7,315,967	24,072	7,340,039	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	841,419		841,419	0	841,419	52.00
53.00	05300 ANESTHESIOLOGY	145,459		145,459	19,217	164,676	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,387,339		4,387,339	9,423	4,396,762	54.00
54.01	05401 CARDIAC REHABILITATION	189,389		189,389	9,786	199,175	54.01
56.01	03470 NUCLEAR MEDICINE	985,282		985,282	0	985,282	56.01
57.00	05700 CT SCAN	974,519		974,519	0	974,519	57.00
58.00	05800 MRI	389,070		389,070	0	389,070	58.00
59.00	05900 CARDIAC CATHETERIZATION	680,285		680,285	15,316	695,601	59.00
60.00	06000 LABORATORY	6,319,092		6,319,092	11,998	6,331,090	60.00
64.00	06400 INTRAVENOUS THERAPY	633,171		633,171	0	633,171	64.00
65.00	06500 RESPIRATORY THERAPY	1,580,043	0	1,580,043	7,061	1,587,104	65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	149,735	0	149,735	0	149,735	65.98
66.00	06600 PHYSICAL THERAPY	2,860,179	0	2,860,179	0	2,860,179	66.00
68.00	06800 SPEECH PATHOLOGY	237,489	0	237,489	0	237,489	68.00
69.00	06900 ELECTROCARDIOLOGY	1,606,805		1,606,805	12,123	1,618,928	69.00
70.01	07001 NEUROLOGY	706,421		706,421	10,073	716,494	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	2,678,487		2,678,487	0	2,678,487	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,681,842		1,681,842	0	1,681,842	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,546,284		7,546,284	0	7,546,284	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	711,973		711,973	0	711,973	90.00
90.01	09002 DIABETES EDUCATION	49,500		49,500	0	49,500	90.01
90.02	09001 PSYCH SERVICES	871,043		871,043	0	871,043	90.02
90.04	09003 ANTI COAGULATION CLINIC	248,077		248,077	0	248,077	90.04
91.00	09100 EMERGENCY	5,393,179		5,393,179	0	5,393,179	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	2,188,098		2,188,098	0	2,188,098	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0		0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0		0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0		0	0	0	99.40
200.00	Subtotal (see instructions)	75,418,562	0	75,418,562	120,288	75,538,850	200.00
201.00	Less Observation Beds	2,188,098		2,188,098		2,188,098	201.00
202.00	Total (see instructions)	73,230,464	0	73,230,464	120,288	73,350,752	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 5/30/2016 11:51 am	
			Title XVIII		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,209,190		15,209,190			30.00
31.00	03100	INTENSIVE CARE UNIT	3,478,427		3,478,427			31.00
40.00	04000	SUBPROVIDER - IPF	1,905,977		1,905,977			40.00
43.00	04300	NURSERY	278,875		278,875			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,807,158	17,256,484	25,063,642	0.291896	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,289,614	882,451	2,172,065	0.387382	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,411,838	1,793,555	3,205,393	0.045379	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,980,883	15,457,320	18,438,203	0.237948	0.000000	54.00
54.01	05401	CARDIAC REHABILITATION	256	372,224	372,480	0.508454	0.000000	54.01
56.01	03470	NUCLEAR MEDICINE	846,511	4,705,591	5,552,102	0.177461	0.000000	56.01
57.00	05700	CT SCAN	7,569,106	23,320,809	30,889,915	0.031548	0.000000	57.00
58.00	05800	MRI	791,002	5,466,300	6,257,302	0.062179	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	868,939	953,525	1,822,464	0.373278	0.000000	59.00
60.00	06000	LABORATORY	18,013,620	29,320,670	47,334,290	0.133499	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	2,955	1,932,251	1,935,206	0.327185	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	6,118,152	1,296,713	7,414,865	0.213091	0.000000	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	1,844	350,712	352,556	0.424713	0.000000	65.98
66.00	06600	PHYSICAL THERAPY	845,139	4,435,292	5,280,431	0.541656	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	78,679	140,412	219,091	1.083974	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	4,647,757	5,926,474	10,574,231	0.151955	0.000000	69.00
70.01	07001	NEUROLOGY	159,641	2,865,200	3,024,841	0.233540	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	571,282	536,215	1,107,497	2.418505	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	771,928	489,577	1,261,505	1.333203	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,101,947	12,294,673	24,396,620	0.309317	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,635	1,321,949	1,330,584	0.535083	0.000000	90.00
90.01	09002	DIABETES EDUCATION	0	25,050	25,050	1.976048	0.000000	90.01
90.02	09001	PSYCH SERVICES	1,114	1,151,497	1,152,611	0.755713	0.000000	90.02
90.04	09003	ANTI COAGULATION CLINIC	1,960	1,117,824	1,119,784	0.221540	0.000000	90.04
91.00	09100	EMERGENCY	5,127,943	14,719,243	19,847,186	0.271735	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	313,906	1,577,353	1,891,259	1.156953	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00		Subtotal (see instructions)	93,204,278	149,709,364	242,913,642			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	93,204,278	149,709,364	242,913,642			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/30/2016 11:51 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.292856		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.387382		52.00
53.00	05300 ANESTHESIOLOGY	0.051375		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.238459		54.00
54.01	05401 CARDIAC REHABILITATION	0.534727		54.01
56.01	03470 NUCLEAR MEDICINE	0.177461		56.01
57.00	05700 CT SCAN	0.031548		57.00
58.00	05800 MRI	0.062179		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.381682		59.00
60.00	06000 LABORATORY	0.133753		60.00
64.00	06400 INTRAVENOUS THERAPY	0.327185		64.00
65.00	06500 RESPIRATORY THERAPY	0.214044		65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	0.424713		65.98
66.00	06600 PHYSICAL THERAPY	0.541656		66.00
68.00	06800 SPEECH PATHOLOGY	1.083974		68.00
69.00	06900 ELECTROCARDIOLOGY	0.153101		69.00
70.01	07001 NEUROLOGY	0.236870		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	2.418505		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	1.333203		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.309317		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.535083		90.00
90.01	09002 DIABETES EDUCATION	1.976048		90.01
90.02	09001 PSYCH SERVICES	0.755713		90.02
90.04	09003 ANTI COAGULATION CLINIC	0.221540		90.04
91.00	09100 EMERGENCY	0.271735		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.156953		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF			99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY			99.40
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: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 5/30/2016 11:51 am	
		Title XIX		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		15,186,463	0	15,186,463	30.00	
31.00	03100 INTENSIVE CARE UNIT		5,353,611	0	5,353,611	31.00	
40.00	04000 SUBPROVIDER - I/PF		2,552,038	1,219	2,553,257	40.00	
43.00	04300 NURSERY		956,303	0	956,303	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		7,315,967	24,072	7,340,039	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		841,419	0	841,419	52.00	
53.00	05300 ANESTHESIOLOGY		145,459	19,217	164,676	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,387,339	9,423	4,396,762	54.00	
54.01	05401 CARDIAC REHABILITATION		189,389	9,786	199,175	54.01	
56.01	03470 NUCLEAR MEDICINE		985,282	0	985,282	56.01	
57.00	05700 CT SCAN		974,519	0	974,519	57.00	
58.00	05800 MRI		389,070	0	389,070	58.00	
59.00	05900 CARDIAC CATHETERIZATION		680,285	15,316	695,601	59.00	
60.00	06000 LABORATORY		6,319,092	11,998	6,331,090	60.00	
64.00	06400 INTRAVENOUS THERAPY		633,171	0	633,171	64.00	
65.00	06500 RESPIRATORY THERAPY	0	1,580,043	7,061	1,587,104	65.00	
65.98	06501 HYPERBARIC OXYGEN THERAPY	0	149,735	0	149,735	65.98	
66.00	06600 PHYSICAL THERAPY	0	2,860,179	0	2,860,179	66.00	
68.00	06800 SPEECH PATHOLOGY	0	237,489	0	237,489	68.00	
69.00	06900 ELECTROCARDIOLOGY		1,606,805	12,123	1,618,928	69.00	
70.01	07001 NEUROLOGY		706,421	10,073	716,494	70.01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		2,678,487	0	2,678,487	71.00	
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		1,681,842	0	1,681,842	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		7,546,284	0	7,546,284	73.00	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		711,973	0	711,973	90.00	
90.01	09002 DIABETES EDUCATION		49,500	0	49,500	90.01	
90.02	09001 PSYCH SERVICES		871,043	0	871,043	90.02	
90.04	09003 ANTI COAGULATION CLINIC		248,077	0	248,077	90.04	
91.00	09100 EMERGENCY		5,393,179	0	5,393,179	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		2,188,098	0	2,188,098	92.00	
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	99.10	
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20	
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30	
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40	
200.00	Subtotal (see instructions)		75,418,562	120,288	75,538,850	200.00	
201.00	Less Observation Beds		2,188,098	0	2,188,098	201.00	
202.00	Total (see instructions)	0	73,230,464	120,288	73,350,752	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 5/30/2016 11:51 am	
			Title XIX		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,209,190		15,209,190			30.00
31.00	03100	INTENSIVE CARE UNIT	3,478,427		3,478,427			31.00
40.00	04000	SUBPROVIDER - IPF	1,905,977		1,905,977			40.00
43.00	04300	NURSERY	278,875		278,875			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,807,158	17,256,484	25,063,642	0.291896	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,289,614	882,451	2,172,065	0.387382	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,411,838	1,793,555	3,205,393	0.045379	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,980,883	15,457,320	18,438,203	0.237948	0.000000	54.00
54.01	05401	CARDIAC REHABILITATION	256	372,224	372,480	0.508454	0.000000	54.01
56.01	03470	NUCLEAR MEDICINE	846,511	4,705,591	5,552,102	0.177461	0.000000	56.01
57.00	05700	CT SCAN	7,569,106	23,320,809	30,889,915	0.031548	0.000000	57.00
58.00	05800	MRI	791,002	5,466,300	6,257,302	0.062179	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	868,939	953,525	1,822,464	0.373278	0.000000	59.00
60.00	06000	LABORATORY	18,013,620	29,320,670	47,334,290	0.133499	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	2,955	1,932,251	1,935,206	0.327185	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	6,118,152	1,296,713	7,414,865	0.213091	0.000000	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	1,844	350,712	352,556	0.424713	0.000000	65.98
66.00	06600	PHYSICAL THERAPY	845,139	4,435,292	5,280,431	0.541656	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	78,679	140,412	219,091	1.083974	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	4,647,757	5,926,474	10,574,231	0.151955	0.000000	69.00
70.01	07001	NEUROLOGY	159,641	2,865,200	3,024,841	0.233540	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	571,282	536,215	1,107,497	2.418505	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	771,928	489,577	1,261,505	1.333203	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,101,947	12,294,673	24,396,620	0.309317	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,635	1,321,949	1,330,584	0.535083	0.000000	90.00
90.01	09002	DIABETES EDUCATION	0	25,050	25,050	1.976048	0.000000	90.01
90.02	09001	PSYCH SERVICES	1,114	1,151,497	1,152,611	0.755713	0.000000	90.02
90.04	09003	ANTI COAGULATION CLINIC	1,960	1,117,824	1,119,784	0.221540	0.000000	90.04
91.00	09100	EMERGENCY	5,127,943	14,719,243	19,847,186	0.271735	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	313,906	1,577,353	1,891,259	1.156953	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00		Subtotal (see instructions)	93,204,278	149,709,364	242,913,642			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	93,204,278	149,709,364	242,913,642			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/30/2016 11:51 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital PPS
		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
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.292856		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.387382		52.00
53.00	05300 ANESTHESIOLOGY	0.051375		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.238459		54.00
54.01	05401 CARDIAC REHABILITATION	0.534727		54.01
56.01	03470 NUCLEAR MEDICINE	0.177461		56.01
57.00	05700 CT SCAN	0.031548		57.00
58.00	05800 MRI	0.062179		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.381682		59.00
60.00	06000 LABORATORY	0.133753		60.00
64.00	06400 INTRAVENOUS THERAPY	0.327185		64.00
65.00	06500 RESPIRATORY THERAPY	0.214044		65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	0.424713		65.98
66.00	06600 PHYSICAL THERAPY	0.541656		66.00
68.00	06800 SPEECH PATHOLOGY	1.083974		68.00
69.00	06900 ELECTROCARDIOLOGY	0.153101		69.00
70.01	07001 NEUROLOGY	0.236870		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	2.418505		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	1.333203		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.309317		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.535083		90.00
90.01	09002 DIABETES EDUCATION	1.976048		90.01
90.02	09001 PSYCH SERVICES	0.755713		90.02
90.04	09003 ANTI COAGULATION CLINIC	0.221540		90.04
91.00	09100 EMERGENCY	0.271735		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.156953		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF			99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY			99.40
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: 140034

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

Worksheet C Part II Date/Time Prepared: 5/30/2016 11:51 am

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,315,967	996,341	6,319,626	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	841,419	82,437	758,982	0	0	52.00
53.00	05300	ANESTHESIOLOGY	145,459	22,137	123,322	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,387,339	791,762	3,595,577	0	0	54.00
54.01	05401	CARDIAC REHABILITATION	189,389	13,797	175,592	0	0	54.01
56.01	03470	NUCLEAR MEDICINE	985,282	52,249	933,033	0	0	56.01
57.00	05700	CT SCAN	974,519	164,355	810,164	0	0	57.00
58.00	05800	MRI	389,070	27,434	361,636	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	680,285	45,958	634,327	0	0	59.00
60.00	06000	LABORATORY	6,319,092	378,323	5,940,769	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	633,171	24,176	608,995	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,580,043	98,282	1,481,761	0	0	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	149,735	23,153	126,582	0	0	65.98
66.00	06600	PHYSICAL THERAPY	2,860,179	198,378	2,661,801	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	237,489	12,615	224,874	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,606,805	181,798	1,425,007	0	0	69.00
70.01	07001	NEUROLOGY	706,421	40,356	666,065	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,678,487	54,936	2,623,551	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,681,842	29,292	1,652,550	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,546,284	232,319	7,313,965	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	711,973	40,214	671,759	0	0	90.00
90.01	09002	DIABETES EDUCATION	49,500	2,026	47,474	0	0	90.01
90.02	09001	PSYCH SERVICES	871,043	87,810	783,233	0	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	248,077	5,455	242,622	0	0	90.04
91.00	09100	EMERGENCY	5,393,179	215,680	5,177,499	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	2,188,098	145,920	2,042,178	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
200.00		Subtotal (sum of lines 50 thru 199)	51,370,147	3,967,203	47,402,944	0	0	200.00
201.00		Less Observation Beds	2,188,098	145,920	2,042,178	0	0	201.00
202.00		Total (line 200 minus line 201)	49,182,049	3,821,283	45,360,766	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part II Date/Time Prepared: 5/30/2016 11:51 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	7,315,967	25,063,642	0.291896	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	841,419	2,172,065	0.387382	52.00
53.00	05300 ANESTHESIOLOGY	145,459	3,205,393	0.045379	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,387,339	18,438,203	0.237948	54.00
54.01	05401 CARDIAC REHABILITATION	189,389	372,480	0.508454	54.01
56.01	03470 NUCLEAR MEDICINE	985,282	5,552,102	0.177461	56.01
57.00	05700 CT SCAN	974,519	30,889,915	0.031548	57.00
58.00	05800 MRI	389,070	6,257,302	0.062179	58.00
59.00	05900 CARDIAC CATHETERIZATION	680,285	1,822,464	0.373278	59.00
60.00	06000 LABORATORY	6,319,092	47,334,290	0.133499	60.00
64.00	06400 INTRAVENOUS THERAPY	633,171	1,935,206	0.327185	64.00
65.00	06500 RESPIRATORY THERAPY	1,580,043	7,414,865	0.213091	65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	149,735	352,556	0.424713	65.98
66.00	06600 PHYSICAL THERAPY	2,860,179	5,280,431	0.541656	66.00
68.00	06800 SPEECH PATHOLOGY	237,489	219,091	1.083974	68.00
69.00	06900 ELECTROCARDIOLOGY	1,606,805	10,574,231	0.151955	69.00
70.01	07001 NEUROLOGY	706,421	3,024,841	0.233540	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	2,678,487	1,107,497	2.418505	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,681,842	1,261,505	1.333203	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,546,284	24,396,620	0.309317	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	711,973	1,330,584	0.535083	90.00
90.01	09002 DIABETES EDUCATION	49,500	25,050	1.976048	90.01
90.02	09001 PSYCH SERVICES	871,043	1,152,611	0.755713	90.02
90.04	09003 ANTI COAGULATION CLINIC	248,077	1,119,784	0.221540	90.04
91.00	09100 EMERGENCY	5,393,179	19,847,186	0.271735	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	2,188,098	1,891,259	1.156953	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF	0	0	0.000000	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0.000000	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0.000000	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0.000000	99.40
200.00	Subtotal (sum of lines 50 thru 199)	51,370,147	222,041,173		200.00
201.00	Less Observation Beds	2,188,098	0		201.00
202.00	Total (line 200 minus line 201)	49,182,049	222,041,173		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part I Date/Time Prepared: 5/30/2016 11:51 am		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	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	1,012,760	0	1,012,760	15,741	64.34	30.00	
31.00	INTENSIVE CARE UNIT	378,294	0	378,294	2,558	147.89	31.00	
40.00	SUBPROVIDER - IPF	114,898	0	114,898	2,707	42.44	40.00	
43.00	NURSERY	71,344		71,344	566	126.05	43.00	
200.00	Total (lines 30-199)	1,577,296		1,577,296	21,572		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	9,291	597,783					30.00
31.00	INTENSIVE CARE UNIT	1,033	152,770					31.00
40.00	SUBPROVIDER - IPF	622	26,398					40.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30-199)	10,946	776,951					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 5/30/2016 11:51 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	996,341	25,063,642	0.039752	3,911,829	155,503	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	82,437	2,172,065	0.037953	6,794	258	52.00
53.00	05300 ANESTHESIOLOGY	22,137	3,205,393	0.006906	365,722	2,526	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	791,762	18,438,203	0.042941	1,896,273	81,428	54.00
54.01	05401 CARDIAC REHABILITATION	13,797	372,480	0.037041	256	9	54.01
56.01	03470 NUCLEAR MEDICINE	52,249	5,552,102	0.009411	472,519	4,447	56.01
57.00	05700 CT SCAN	164,355	30,889,915	0.005321	4,181,175	22,248	57.00
58.00	05800 MRI	27,434	6,257,302	0.004384	432,450	1,896	58.00
59.00	05900 CARDIAC CATHETERIZATION	45,958	1,822,464	0.025218	317,366	8,003	59.00
60.00	06000 LABORATORY	378,323	47,334,290	0.007993	10,822,189	86,502	60.00
64.00	06400 INTRAVENOUS THERAPY	24,176	1,935,206	0.012493	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	98,282	7,414,865	0.013255	3,888,082	51,537	65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	23,153	352,556	0.065672	1,844	121	65.98
66.00	06600 PHYSICAL THERAPY	198,378	5,280,431	0.037569	670,497	25,190	66.00
68.00	06800 SPEECH PATHOLOGY	12,615	219,091	0.057579	65,680	3,782	68.00
69.00	06900 ELECTROCARDIOLOGY	181,798	10,574,231	0.017193	3,146,730	54,102	69.00
70.01	07001 NEUROLOGY	40,356	3,024,841	0.013342	105,125	1,403	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	54,936	1,107,497	0.049604	375,108	18,607	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	29,292	1,261,505	0.023220	337,533	7,838	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	232,319	24,396,620	0.009523	7,693,687	73,267	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	40,214	1,330,584	0.030223	0	0	90.00
90.01	09002 DIABETES EDUCATION	2,026	25,050	0.080878	0	0	90.01
90.02	09001 PSYCH SERVICES	87,810	1,152,611	0.076184	0	0	90.02
90.04	09003 ANTI COAGULATION CLINIC	5,455	1,119,784	0.004871	0	0	90.04
91.00	09100 EMERGENCY	215,680	19,847,186	0.010867	2,383,880	25,906	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	145,920	1,891,259	0.077155	295,614	22,808	92.00
200.00	Total (lines 50-199)	3,967,203	222,041,173		41,370,353	647,381	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part III Date/Time Prepared: 5/30/2016 11:51 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,741	0.00	9,291	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,558	0.00	1,033	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,707	0.00	622	0		40.00
43.00	04300	NURSERY	566	0.00	0	0		43.00
200.00		Total (lines 30-199)	21,572		10,946	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/30/2016 11:51 am
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Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
54.01	05401	CARDIAC REHABILITATION	0	0	0	0	0 54.01
56.01	03470	NUCLEAR MEDICINE	0	0	0	0	0 56.01
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 65.98
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.01	07001	NEUROLOGY	0	0	0	0	0 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09002	DIABETES EDUCATION	0	0	0	0	0 90.01
90.02	09001	PSYCH SERVICES	0	0	0	0	0 90.02
90.04	09003	ANTI COAGULATION CLINIC	0	0	0	0	0 90.04
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	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: 140034

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

Worksheet D
Part IV
Date/Time Prepared:
5/30/2016 11:51 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	25,063,642	0.000000	0.000000	3,911,829	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,172,065	0.000000	0.000000	6,794	52.00
53.00	05300	ANESTHESIOLOGY	0	3,205,393	0.000000	0.000000	365,722	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,438,203	0.000000	0.000000	1,896,273	54.00
54.01	05401	CARDIAC REHABILITATION	0	372,480	0.000000	0.000000	256	54.01
56.01	03470	NUCLEAR MEDICINE	0	5,552,102	0.000000	0.000000	472,519	56.01
57.00	05700	CT SCAN	0	30,889,915	0.000000	0.000000	4,181,175	57.00
58.00	05800	MRI	0	6,257,302	0.000000	0.000000	432,450	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,822,464	0.000000	0.000000	317,366	59.00
60.00	06000	LABORATORY	0	47,334,290	0.000000	0.000000	10,822,189	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,935,206	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,414,865	0.000000	0.000000	3,888,082	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	0	352,556	0.000000	0.000000	1,844	65.98
66.00	06600	PHYSICAL THERAPY	0	5,280,431	0.000000	0.000000	670,497	66.00
68.00	06800	SPEECH PATHOLOGY	0	219,091	0.000000	0.000000	65,680	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,574,231	0.000000	0.000000	3,146,730	69.00
70.01	07001	NEUROLOGY	0	3,024,841	0.000000	0.000000	105,125	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,107,497	0.000000	0.000000	375,108	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	1,261,505	0.000000	0.000000	337,533	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,396,620	0.000000	0.000000	7,693,687	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,330,584	0.000000	0.000000	0	90.00
90.01	09002	DIABETES EDUCATION	0	25,050	0.000000	0.000000	0	90.01
90.02	09001	PSYCH SERVICES	0	1,152,611	0.000000	0.000000	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	0	1,119,784	0.000000	0.000000	0	90.04
91.00	09100	EMERGENCY	0	19,847,186	0.000000	0.000000	2,383,880	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	1,891,259	0.000000	0.000000	295,614	92.00
200.00		Total (lines 50-199)	0	222,041,173			41,370,353	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/30/2016 11:51 am
	Title XVIII	Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	6,440,182	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	497,987	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,931,455	0	54.00
54.01	05401 CARDIAC REHABILITATION	0	200,448	0	54.01
56.01	03470 NUCLEAR MEDICINE	0	2,058,525	0	56.01
57.00	05700 CT SCAN	0	7,824,525	0	57.00
58.00	05800 MRI	0	1,727,400	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	391,122	0	59.00
60.00	06000 LABORATORY	0	6,078,169	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	221,056	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	494,543	0	65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	0	0	0	65.98
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	2,897,972	0	69.00
70.01	07001 NEUROLOGY	0	127,277	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	130,373	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	254,730	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8,253,740	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	892,389	0	90.00
90.01	09002 DIABETES EDUCATION	0	0	0	90.01
90.02	09001 PSYCH SERVICES	0	0	0	90.02
90.04	09003 ANTI COAGULATION CLINIC	0	0	0	90.04
91.00	09100 EMERGENCY	0	4,895,085	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	673,421	0	92.00
200.00	Total (lines 50-199)	0	49,990,399	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/30/2016 11:51 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.291896	6,440,182	0	0	1,879,863	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.387382	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.045379	497,987	0	0	22,598	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237948	5,931,455	0	0	1,411,378	54.00
54.01	05401	CARDIAC REHABILITATION	0.508454	200,448	0	0	101,919	54.01
56.01	03470	NUCLEAR MEDICINE	0.177461	2,058,525	0	0	365,308	56.01
57.00	05700	CT SCAN	0.031548	7,824,525	0	0	246,848	57.00
58.00	05800	MRI	0.062179	1,727,400	0	0	107,408	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.373278	391,122	0	0	145,997	59.00
60.00	06000	LABORATORY	0.133499	6,078,169	873	0	811,429	60.00
64.00	06400	INTRAVENOUS THERAPY	0.327185	221,056	0	0	72,326	64.00
65.00	06500	RESPIRATORY THERAPY	0.213091	494,543	0	0	105,383	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	0.424713	0	0	0	0	65.98
66.00	06600	PHYSICAL THERAPY	0.541656	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	1.083974	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151955	2,897,972	0	0	440,361	69.00
70.01	07001	NEUROLOGY	0.233540	127,277	0	0	29,724	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2.418505	130,373	0	0	315,308	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1.333203	254,730	0	0	339,607	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.309317	8,253,740	0	318,570	2,553,022	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.535083	892,389	0	0	477,502	90.00
90.01	09002	DIABETES EDUCATION	1.976048	0	0	0	0	90.01
90.02	09001	PSYCH SERVICES	0.755713	0	0	0	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	0.221540	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.271735	4,895,085	0	0	1,330,166	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	1.156953	673,421	0	0	779,116	92.00
200.00		Subtotal (see instructions)		49,990,399	873	318,570	11,535,263	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		49,990,399	873	318,570	11,535,263	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/30/2016 11:51 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
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
54.01 05401 CARDIAC REHABILITATION	0	0		54.01
56.01 03470 NUCLEAR MEDICINE	0	0		56.01
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	117	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
65.98 06501 HYPERBARI C OXYGEN THERAPY	0	0		65.98
66.00 06600 PHYSICAL THERAPY	0	0		66.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.01 07001 NEUROLOGY	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	98,539		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09002 DIABETES EDUCATION	0	0		90.01
90.02 09001 PSYCH SERVICES	0	0		90.02
90.04 09003 ANTI COAGULATION CLINIC	0	0		90.04
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)	0	0		92.00
200.00 Subtotal (see instructions)	117	98,539		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	117	98,539		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140034 Component CCN: 14S034		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part II Date/Time Prepared: 5/30/2016 11:51 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	996,341	25,063,642	0.039752	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	82,437	2,172,065	0.037953	0	0 52.00
53.00	05300	ANESTHESIOLOGY	22,137	3,205,393	0.006906	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	791,762	18,438,203	0.042941	11,608	498 54.00
54.01	05401	CARDIAC REHABILITATION	13,797	372,480	0.037041	0	0 54.01
56.01	03470	NUCLEAR MEDICINE	52,249	5,552,102	0.009411	10,420	98 56.01
57.00	05700	CT SCAN	164,355	30,889,915	0.005321	22,300	119 57.00
58.00	05800	MRI	27,434	6,257,302	0.004384	3,800	17 58.00
59.00	05900	CARDIAC CATHETERIZATION	45,958	1,822,464	0.025218	0	0 59.00
60.00	06000	LABORATORY	378,323	47,334,290	0.007993	229,806	1,837 60.00
64.00	06400	INTRAVENOUS THERAPY	24,176	1,935,206	0.012493	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	98,282	7,414,865	0.013255	37,284	494 65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	23,153	352,556	0.065672	0	0 65.98
66.00	06600	PHYSICAL THERAPY	198,378	5,280,431	0.037569	4,444	167 66.00
68.00	06800	SPEECH PATHOLOGY	12,615	219,091	0.057579	191	11 68.00
69.00	06900	ELECTROCARDIOLOGY	181,798	10,574,231	0.017193	17,362	299 69.00
70.01	07001	NEUROLOGY	40,356	3,024,841	0.013342	0	0 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	54,936	1,107,497	0.049604	538	27 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	29,292	1,261,505	0.023220	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	232,319	24,396,620	0.009523	83,904	799 73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	40,214	1,330,584	0.030223	0	0 90.00
90.01	09002	DIABETES EDUCATION	2,026	25,050	0.080878	0	0 90.01
90.02	09001	PSYCH SERVICES	87,810	1,152,611	0.076184	0	0 90.02
90.04	09003	ANTI COAGULATION CLINIC	5,455	1,119,784	0.004871	0	0 90.04
91.00	09100	EMERGENCY	215,680	19,847,186	0.010867	92,822	1,009 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	1,891,259	0.000000	0	0 92.00
200.00		Total (lines 50-199)	3,821,283	222,041,173		514,479	5,375 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140034 Component CCN: 14S034	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/30/2016 11:51 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	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	CARDIAC REHABILITATION	0	0	0	0	54.01
56.01	03470	NUCLEAR MEDICINE	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	0	0	0	0	65.98
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.01	07001	NEUROLOGY	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09002	DIABETES EDUCATION	0	0	0	0	90.01
90.02	09001	PSYCH SERVICES	0	0	0	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140034 Component CCN: 14S034		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part IV Date/Time Prepared: 5/30/2016 11:51 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	25,063,642	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,172,065	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,205,393	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,438,203	0.000000	0.000000	11,608	54.00
54.01	05401	CARDIAC REHABILITATION	0	372,480	0.000000	0.000000	0	54.01
56.01	03470	NUCLEAR MEDICINE	0	5,552,102	0.000000	0.000000	10,420	56.01
57.00	05700	CT SCAN	0	30,889,915	0.000000	0.000000	22,300	57.00
58.00	05800	MRI	0	6,257,302	0.000000	0.000000	3,800	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,822,464	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	47,334,290	0.000000	0.000000	229,806	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,935,206	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,414,865	0.000000	0.000000	37,284	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	0	352,556	0.000000	0.000000	0	65.98
66.00	06600	PHYSICAL THERAPY	0	5,280,431	0.000000	0.000000	4,444	66.00
68.00	06800	SPEECH PATHOLOGY	0	219,091	0.000000	0.000000	191	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,574,231	0.000000	0.000000	17,362	69.00
70.01	07001	NEUROLOGY	0	3,024,841	0.000000	0.000000	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,107,497	0.000000	0.000000	538	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	1,261,505	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,396,620	0.000000	0.000000	83,904	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,330,584	0.000000	0.000000	0	90.00
90.01	09002	DIABETES EDUCATION	0	25,050	0.000000	0.000000	0	90.01
90.02	09001	PSYCH SERVICES	0	1,152,611	0.000000	0.000000	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	0	1,119,784	0.000000	0.000000	0	90.04
91.00	09100	EMERGENCY	0	19,847,186	0.000000	0.000000	92,822	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	1,891,259	0.000000	0.000000	0	92.00
200.00		Total (Lines 50-199)	0	222,041,173			514,479	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/30/2016 11:51 am
	Component CCN: 14S034	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
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
54.01 05401 CARDIAC REHABILITATION	0	0	0	54.01
56.01 03470 NUCLEAR MEDICINE	0	0	0	56.01
57.00 05700 CT SCAN	0	0	0	57.00
58.00 05800 MRI	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
65.98 06501 HYPERBARIC OXYGEN THERAPY	0	0	0	65.98
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.01 07001 NEUROLOGY	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	390	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
90.01 09002 DIABETES EDUCATION	0	0	0	90.01
90.02 09001 PSYCH SERVICES	0	207,648	0	90.02
90.04 09003 ANTI COAGULATION CLINIC	0	0	0	90.04
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0	92.00
200.00 Total (Lines 50-199)	0	208,038	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140034 Component CCN: 14S034	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/30/2016 11:51 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.291896	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.387382	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.045379	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.237948	0	0	0	0	54.00
54.01 05401 CARDIAC REHABILITATION	0.508454	0	0	0	0	54.01
56.01 03470 NUCLEAR MEDICINE	0.177461	0	0	0	0	56.01
57.00 05700 CT SCAN	0.031548	0	0	0	0	57.00
58.00 05800 MRI	0.062179	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.373278	0	0	0	0	59.00
60.00 06000 LABORATORY	0.133499	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0.327185	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.213091	0	0	0	0	65.00
65.98 06501 HYPERBARIC OXYGEN THERAPY	0.424713	0	0	0	0	65.98
66.00 06600 PHYSICAL THERAPY	0.541656	0	0	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	1.083974	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.151955	0	0	0	0	69.00
70.01 07001 NEUROLOGY	0.233540	0	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	2.418505	0	0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	1.333203	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.309317	390	0	1,556	121	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.535083	0	0	0	0	90.00
90.01 09002 DIABETES EDUCATION	1.976048	0	0	0	0	90.01
90.02 09001 PSYCH SERVICES	0.755713	207,648	0	0	156,922	90.02
90.04 09003 ANTI COAGULATION CLINIC	0.221540	0	0	0	0	90.04
91.00 09100 EMERGENCY	0.271735	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)	1.156953	0	0	0	0	92.00
200.00	Subtotal (see instructions)		208,038	0	1,556	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		208,038	0	1,556	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/30/2016 11:51 am
	Component CCN: 14S034	Title XVIII	Subprovider - IPF

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
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
54.01 05401 CARDIAC REHABILITATION	0	0	54.01
56.01 03470 NUCLEAR MEDICINE	0	0	56.01
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
65.98 06501 HYPERBARIC OXYGEN THERAPY	0	0	65.98
66.00 06600 PHYSICAL THERAPY	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.01 07001 NEUROLOGY	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	481	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
90.01 09002 DIABETES EDUCATION	0	0	90.01
90.02 09001 PSYCH SERVICES	0	0	90.02
90.04 09003 ANTI COAGULATION CLINIC	0	0	90.04
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0	92.00
200.00 Subtotal (see instructions)	0	481	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	481	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part I Date/Time Prepared: 5/30/2016 11:51 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	1,012,760	0	1,012,760	15,741	64.34	30.00
31.00	INTENSIVE CARE UNIT	378,294	0	378,294	2,558	147.89	31.00
40.00	SUBPROVIDER - IPF	114,898	0	114,898	2,707	42.44	40.00
43.00	NURSERY	71,344		71,344	566	126.05	43.00
200.00	Total (lines 30-199)	1,577,296		1,577,296	21,572		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	2,166	139,360				
31.00	INTENSIVE CARE UNIT	405	59,895				
40.00	SUBPROVIDER - IPF	1,578	66,970				
43.00	NURSERY	521	65,672				
200.00	Total (lines 30-199)	4,670	331,897				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 5/30/2016 11:51 am
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	996,341	25,063,642	0.039752	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	82,437	2,172,065	0.037953	0	0	52.00
53.00	05300	ANESTHESIOLOGY	22,137	3,205,393	0.006906	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	791,762	18,438,203	0.042941	0	0	54.00
54.01	05401	CARDIAC REHABILITATION	13,797	372,480	0.037041	0	0	54.01
56.01	03470	NUCLEAR MEDICINE	52,249	5,552,102	0.009411	0	0	56.01
57.00	05700	CT SCAN	164,355	30,889,915	0.005321	0	0	57.00
58.00	05800	MRI	27,434	6,257,302	0.004384	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	45,958	1,822,464	0.025218	0	0	59.00
60.00	06000	LABORATORY	378,323	47,334,290	0.007993	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	24,176	1,935,206	0.012493	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	98,282	7,414,865	0.013255	0	0	65.00
65.98	06501	HYPERBARI C OXYGEN THERAPY	23,153	352,556	0.065672	0	0	65.98
66.00	06600	PHYSICAL THERAPY	198,378	5,280,431	0.037569	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	12,615	219,091	0.057579	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	181,798	10,574,231	0.017193	0	0	69.00
70.01	07001	NEUROLOGY	40,356	3,024,841	0.013342	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	54,936	1,107,497	0.049604	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	29,292	1,261,505	0.023220	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	232,319	24,396,620	0.009523	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	40,214	1,330,584	0.030223	0	0	90.00
90.01	09002	DIABETES EDUCATION	2,026	25,050	0.080878	0	0	90.01
90.02	09001	PSYCH SERVICES	87,810	1,152,611	0.076184	0	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	5,455	1,119,784	0.004871	0	0	90.04
91.00	09100	EMERGENCY	215,680	19,847,186	0.010867	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	145,920	1,891,259	0.077155	0	0	92.00
200.00		Total (lines 50-199)	3,967,203	222,041,173		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part III Date/Time Prepared: 5/30/2016 11:51 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,741	0.00	2,166	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,558	0.00	405	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,707	0.00	1,578	0		40.00
43.00	04300	NURSERY	566	0.00	521	0		43.00
200.00		Total (lines 30-199)	21,572		4,670	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/30/2016 11:51 am
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Cost Center Description	Title XIX				Hospital	PPS
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 05401 CARDIAC REHABILITATION	0	0	0	0	0	54.01
56.01 03470 NUCLEAR MEDICINE	0	0	0	0	0	56.01
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.98 06501 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	65.98
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.01 07001 NEUROLOGY	0	0	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09002 DIABETES EDUCATION	0	0	0	0	0	90.01
90.02 09001 PSYCH SERVICES	0	0	0	0	0	90.02
90.04 09003 ANTI COAGULATION CLINIC	0	0	0	0	0	90.04
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	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: 140034

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

Worksheet D
Part IV
Date/Time Prepared:
5/30/2016 11:51 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	PPS	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)				
		6.00	7.00	8.00	9.00	10.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	25,063,642	0.000000	0.000000		0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,172,065	0.000000	0.000000		0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,205,393	0.000000	0.000000		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,438,203	0.000000	0.000000		0	54.00
54.01	05401	CARDIAC REHABILITATION	0	372,480	0.000000	0.000000		0	54.01
56.01	03470	NUCLEAR MEDICINE	0	5,552,102	0.000000	0.000000		0	56.01
57.00	05700	CT SCAN	0	30,889,915	0.000000	0.000000		0	57.00
58.00	05800	MRI	0	6,257,302	0.000000	0.000000		0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,822,464	0.000000	0.000000		0	59.00
60.00	06000	LABORATORY	0	47,334,290	0.000000	0.000000		0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,935,206	0.000000	0.000000		0	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,414,865	0.000000	0.000000		0	65.00
65.98	06501	HYPERBARI C OXYGEN THERAPY	0	352,556	0.000000	0.000000		0	65.98
66.00	06600	PHYSICAL THERAPY	0	5,280,431	0.000000	0.000000		0	66.00
68.00	06800	SPEECH PATHOLOGY	0	219,091	0.000000	0.000000		0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,574,231	0.000000	0.000000		0	69.00
70.01	07001	NEUROLOGY	0	3,024,841	0.000000	0.000000		0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,107,497	0.000000	0.000000		0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	1,261,505	0.000000	0.000000		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,396,620	0.000000	0.000000		0	73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	1,330,584	0.000000	0.000000		0	90.00
90.01	09002	DIABETES EDUCATION	0	25,050	0.000000	0.000000		0	90.01
90.02	09001	PSYCH SERVICES	0	1,152,611	0.000000	0.000000		0	90.02
90.04	09003	ANTI COAGULATION CLINIC	0	1,119,784	0.000000	0.000000		0	90.04
91.00	09100	EMERGENCY	0	19,847,186	0.000000	0.000000		0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	1,891,259	0.000000	0.000000		0	92.00
200.00		Total (lines 50-199)	0	222,041,173				0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/30/2016 11:51 am
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Cost Center Description		Title XIX			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
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
54.01	05401 CARDIAC REHABILITATION	0	0	0		54.01
56.01	03470 NUCLEAR MEDICINE	0	0	0		56.01
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MRI	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	0	0	0		65.98
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.01	07001 NEUROLOGY	0	0	0		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09002 DIABETES EDUCATION	0	0	0		90.01
90.02	09001 PSYCH SERVICES	0	0	0		90.02
90.04	09003 ANTI COAGULATION CLINIC	0	0	0		90.04
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	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: 140034 Component CCN: 14S034	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 5/30/2016 11:51 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	996,341	25,063,642	0.039752	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	82,437	2,172,065	0.037953	0	0	52.00
53.00	05300 ANESTHESIOLOGY	22,137	3,205,393	0.006906	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	791,762	18,438,203	0.042941	0	0	54.00
54.01	05401 CARDIAC REHABILITATION	13,797	372,480	0.037041	0	0	54.01
56.01	03470 NUCLEAR MEDICINE	52,249	5,552,102	0.009411	0	0	56.01
57.00	05700 CT SCAN	164,355	30,889,915	0.005321	0	0	57.00
58.00	05800 MRI	27,434	6,257,302	0.004384	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	45,958	1,822,464	0.025218	0	0	59.00
60.00	06000 LABORATORY	378,323	47,334,290	0.007993	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	24,176	1,935,206	0.012493	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	98,282	7,414,865	0.013255	0	0	65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	23,153	352,556	0.065672	0	0	65.98
66.00	06600 PHYSICAL THERAPY	198,378	5,280,431	0.037569	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	12,615	219,091	0.057579	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	181,798	10,574,231	0.017193	0	0	69.00
70.01	07001 NEUROLOGY	40,356	3,024,841	0.013342	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	54,936	1,107,497	0.049604	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	29,292	1,261,505	0.023220	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	232,319	24,396,620	0.009523	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	40,214	1,330,584	0.030223	0	0	90.00
90.01	09002 DIABETES EDUCATION	2,026	25,050	0.080878	0	0	90.01
90.02	09001 PSYCH SERVICES	87,810	1,152,611	0.076184	0	0	90.02
90.04	09003 ANTI COAGULATION CLINIC	5,455	1,119,784	0.004871	0	0	90.04
91.00	09100 EMERGENCY	215,680	19,847,186	0.010867	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	1,891,259	0.000000	0	0	92.00
200.00	Total (Lines 50-199)	3,821,283	222,041,173		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140034 Component CCN: 14S034	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/30/2016 11:51 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	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	CARDIAC REHABILITATION	0	0	0	0	54.01
56.01	03470	NUCLEAR MEDICINE	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	0	0	0	0	65.98
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.01	07001	NEUROLOGY	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09002	DIABETES EDUCATION	0	0	0	0	90.01
90.02	09001	PSYCH SERVICES	0	0	0	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140034 Component CCN: 14S034	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/30/2016 11:51 am
Title XIX		Subprovider - IPF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 + col. 7)	
	6.00	7.00	8.00	9.00	10.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	25,063,642	0.000000	0.000000	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	2,172,065	0.000000	0.000000	0 52.00
53.00 05300 ANESTHESIOLOGY	0	3,205,393	0.000000	0.000000	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	18,438,203	0.000000	0.000000	0 54.00
54.01 05401 CARDIAC REHABILITATION	0	372,480	0.000000	0.000000	0 54.01
56.01 03470 NUCLEAR MEDICINE	0	5,552,102	0.000000	0.000000	0 56.01
57.00 05700 CT SCAN	0	30,889,915	0.000000	0.000000	0 57.00
58.00 05800 MRI	0	6,257,302	0.000000	0.000000	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	1,822,464	0.000000	0.000000	0 59.00
60.00 06000 LABORATORY	0	47,334,290	0.000000	0.000000	0 60.00
64.00 06400 INTRAVENOUS THERAPY	0	1,935,206	0.000000	0.000000	0 64.00
65.00 06500 RESPIRATORY THERAPY	0	7,414,865	0.000000	0.000000	0 65.00
65.98 06501 HYPERBARI C OXYGEN THERAPY	0	352,556	0.000000	0.000000	0 65.98
66.00 06600 PHYSICAL THERAPY	0	5,280,431	0.000000	0.000000	0 66.00
68.00 06800 SPEECH PATHOLOGY	0	219,091	0.000000	0.000000	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0	10,574,231	0.000000	0.000000	0 69.00
70.01 07001 NEUROLOGY	0	3,024,841	0.000000	0.000000	0 70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	1,107,497	0.000000	0.000000	0 71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	1,261,505	0.000000	0.000000	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	24,396,620	0.000000	0.000000	0 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	1,330,584	0.000000	0.000000	0 90.00
90.01 09002 DIABETES EDUCATION	0	25,050	0.000000	0.000000	0 90.01
90.02 09001 PSYCH SERVICES	0	1,152,611	0.000000	0.000000	0 90.02
90.04 09003 ANTI COAGULATION CLINIC	0	1,119,784	0.000000	0.000000	0 90.04
91.00 09100 EMERGENCY	0	19,847,186	0.000000	0.000000	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	1,891,259	0.000000	0.000000	0 92.00
200.00 Total (Lines 50-199)	0	222,041,173			0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140034 Component CCN: 14S034	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/30/2016 11:51 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
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
54.01	05401 CARDIAC REHABILITATION	0	0	0	54.01
56.01	03470 NUCLEAR MEDICINE	0	0	0	56.01
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	0	0	0	65.98
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.01	07001 NEUROLOGY	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09002 DIABETES EDUCATION	0	0	0	90.01
90.02	09001 PSYCH SERVICES	0	0	0	90.02
90.04	09003 ANTI COAGULATION CLINIC	0	0	0	90.04
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0	92.00
200.00	Total (Lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2016 11:51 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		15,741	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		15,741	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.		13,421	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		52	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		9,291	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)		15,186,463	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)		15,186,463	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		15,151,128	28.00
29.00	Private room charges (excluding swing-bed charges)		58,062	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		15,093,066	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.002332	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		4.33	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		290,251.27	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)		15,186,463	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)		964.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,963,678	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		8,963,678	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/30/2016 11:51 am	
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)	
Title XVIII		1.00	2.00	3.00	4.00	5.00	
Hospital							
PPS							
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	5,353,611	2,558	2,092.89	1,033	2,161,955	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)					9,931,460	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					21,057,093	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)					750,553	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					647,381	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,397,934	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					19,659,159	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)					2,268	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					964.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,188,098	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/30/2016 11:51 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	1,012,760	15,186,463	0.066688	2,188,098	145,920	90.00
91.00	Nursing School cost	0	15,186,463	0.000000	2,188,098	0	91.00
92.00	Allied health cost	0	15,186,463	0.000000	2,188,098	0	92.00
93.00	All other Medical Education	0	15,186,463	0.000000	2,188,098	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034 Component CCN: 14S034	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/30/2016 11:51 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)		2,707	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,707	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,707	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)		622	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)		2,553,257	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)		2,553,257	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)		2,553,257	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)		943.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		586,677	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)		586,677	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
		Component CCN: 14S034				Date/Time Prepared: 5/30/2016 11:51 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)					102,023		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					688,700		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)					26,398		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					5,375		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					31,773		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					656,927		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: 140034 Component CCN: 14S034		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/30/2016 11:51 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	114,898	2,553,257	0.045001	0	0	90.00
91.00	Nursing School cost	0	2,553,257	0.000000	0	0	91.00
92.00	Allied health cost	0	2,553,257	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,553,257	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/30/2016 11:51 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		15,741	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		15,741	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.		13,421	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		52	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,166	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)		566	15.00
16.00	Nursery days (title V or XIX only)		521	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)		15,186,463	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)		15,186,463	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		15,151,128	28.00
29.00	Private room charges (excluding swing-bed charges)		58,062	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		15,093,066	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.002332	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		4.33	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		290,251.27	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)		15,186,463	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)		964.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,089,692	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)		2,089,692	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
Date/Time Prepared: 5/30/2016 11:51 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)		
42.00 NURSERY (title V & XIX only)	956,303	566	1,689.58	521	880,271		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	5,353,611	2,558	2,092.89	405	847,620		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)						3,817,583	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)						264,927	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)						264,927	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						3,552,656	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)						2,268	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						964.77	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						2,188,098	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/30/2016 11:51 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,012,760	15,186,463	0.066688	2,188,098	145,920	90.00
91.00	Nursing School cost	0	15,186,463	0.000000	2,188,098	0	91.00
92.00	Allied health cost	0	15,186,463	0.000000	2,188,098	0	92.00
93.00	All other Medical Education	0	15,186,463	0.000000	2,188,098	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034 Component CCN: 14S034	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/30/2016 11:51 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)		2,707	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,707	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,707	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,578	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)		566	15.00
16.00	Nursery days (title V or XIX only)		521	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)		2,553,257	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)		2,553,257	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)		2,553,257	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)		943.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,488,385	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,488,385	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
		Component CCN: 14S034				Date/Time Prepared: 5/30/2016 11:51 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)					1,488,385		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)					66,970		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)					66,970		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,421,415		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: 140034 Component CCN: 14S034		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/30/2016 11:51 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	114,898	2,553,257	0.045001	0	0	90.00
91.00	Nursing School cost	0	2,553,257	0.000000	0	0	91.00
92.00	Allied health cost	0	2,553,257	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,553,257	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/30/2016 11:51 am	
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		7,132,618	30.00
31.00	03100	INTENSIVE CARE UNIT		1,532,472	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	0.292856	3,911,829	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.387382	6,794	52.00
53.00	05300	ANESTHESIOLOGY	0.051375	365,722	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.238459	1,896,273	54.00
54.01	05401	CARDIAC REHABILITATION	0.534727	256	54.01
56.01	03470	NUCLEAR MEDICINE	0.177461	472,519	56.01
57.00	05700	CT SCAN	0.031548	4,181,175	57.00
58.00	05800	MRI	0.062179	432,450	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.381682	317,366	59.00
60.00	06000	LABORATORY	0.133753	10,822,189	60.00
64.00	06400	INTRAVENOUS THERAPY	0.327185	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.214044	3,888,082	65.00
65.98	06501	HYPERBARI C OXYGEN THERAPY	0.424713	1,844	65.98
66.00	06600	PHYSICAL THERAPY	0.541656	670,497	66.00
68.00	06800	SPEECH PATHOLOGY	1.083974	65,680	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153101	3,146,730	69.00
70.01	07001	NEUROLOGY	0.236870	105,125	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2.418505	375,108	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1.333203	337,533	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.309317	7,693,687	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.535083	0	90.00
90.01	09002	DIABETES EDUCATION	1.976048	0	90.01
90.02	09001	PSYCH SERVICES	0.755713	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	0.221540	0	90.04
91.00	09100	EMERGENCY	0.271735	2,383,880	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	1.156953	295,614	92.00
200.00		Total (sum of lines 50-94 and 96-98)		41,370,353	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)		41,370,353	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140034 Component CCN: 14S034	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/30/2016 11:51 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		438,471		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.292856	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.387382	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.051375	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.238459	11,608	2,768	54.00
54.01	05401 CARDIAC REHABILITATION	0.534727	0	0	54.01
56.01	03470 NUCLEAR MEDICINE	0.177461	10,420	1,849	56.01
57.00	05700 CT SCAN	0.031548	22,300	704	57.00
58.00	05800 MRI	0.062179	3,800	236	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.381682	0	0	59.00
60.00	06000 LABORATORY	0.133753	229,806	30,737	60.00
64.00	06400 INTRAVENOUS THERAPY	0.327185	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.214044	37,284	7,980	65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	0.424713	0	0	65.98
66.00	06600 PHYSICAL THERAPY	0.541656	4,444	2,407	66.00
68.00	06800 SPEECH PATHOLOGY	1.083974	191	207	68.00
69.00	06900 ELECTROCARDIOLOGY	0.153101	17,362	2,658	69.00
70.01	07001 NEUROLOGY	0.236870	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	2.418505	538	1,301	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	1.333203	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.309317	83,904	25,953	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.535083	0	0	90.00
90.01	09002 DIABETES EDUCATION	1.976048	0	0	90.01
90.02	09001 PSYCH SERVICES	0.755713	0	0	90.02
90.04	09003 ANTI COAGULATION CLINIC	0.221540	0	0	90.04
91.00	09100 EMERGENCY	0.271735	92,822	25,223	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	1.156953	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		514,479	102,023	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		514,479		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/30/2016 11:51 am
		Title XVII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		11,321,104	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,538,476	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)		234,199	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)		89.99	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (F)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.37	30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.59	31.00
32.00	Sum of lines 30 and 31		27.96	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.29	33.00
34.00	Disproportionate share adjustment (see instructions)		456,561	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/30/2016 11:51 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			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)		0.000130055	0.000129857	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		994,613	831,883	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		743,916	209,107	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		953,023		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		16,503,363		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		17,944,844		48.00
49.00	Total payment for inpatient operating costs (see instructions)		17,584,474		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,192,720		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		1,588		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		18,778,782		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		18,778,782		61.00
62.00	Deductibles billed to program beneficiaries		1,945,908		62.00
63.00	Coinurance billed to program beneficiaries		114,345		63.00
64.00	Allowable bad debts (see instructions)		792,206		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		514,934		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		659,822		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		17,233,463		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)		8,046		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-18,557		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		115,957		70.93
70.94	HRR adjustment amount (see instructions)		-256,107		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/30/2016 11:51 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		17,082,802		71.00
71.01	Sequestration adjustment (see instructions)		341,656		71.01
72.00	Interim payments		16,611,116		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)		130,030		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		0		75.00
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		808,612	272,499	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		1.0058983963	1.0120234049	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		4,770	3,276	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.9816	0.9865	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-14,878	-3,679	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140034

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/30/2016 11:51 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	11,321,104	0	11,321,104	0	11,321,104	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,538,476	0	0	3,538,476	3,538,476	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	234,199	0	210,983	23,216	234,199	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	0.1229	0.1229	0.1229	0.1229		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	456,561	0	347,841	108,720	456,561	11.00
11.01	Uncompensated care payments	36.00	953,023	0	743,916	209,107	953,023	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	16,503,363	0	12,623,844	3,879,519	16,503,363	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	17,944,844	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	17,584,474	0	13,704,955	3,879,519	17,584,474	15.00
16.00	Payment for inpatient program capital	50.00	1,192,720	0	909,157	283,563	1,192,720	16.00
17.00	Special add-on payments for new technologies	54.00	1,588	0	1,588	0	1,588	17.00
17.01	Net organ acquisition 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

Provider CCN: 140034

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/30/2016 11:51 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	14,615,700	4,163,082	18,778,782	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	1,181,356	0	899,665	281,691	1,181,356	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	11,364	0	11,364	1,872	13,236	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	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,192,720	0	909,157	283,563	1,192,720	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.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2016 11:51 am
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		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 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	11,321,104	11,321,104		11,321,104	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,538,476		3,538,476	3,538,476	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	234,199	210,983	23,216	234,199	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	0.1229	0.1229	0.1229		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	456,561	347,841	108,720	456,561	11.00
11.01	Uncompensated care payments	36.00	953,023	743,916	209,107	953,023	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	16,503,363	12,623,844	3,879,519	16,503,363	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	17,944,844	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	17,584,474	13,704,955	3,879,519	17,584,474	15.00
16.00	Payment for inpatient program capital	50.00	1,192,720	911,029	281,691	1,192,720	16.00
17.00	Special add-on payments for new technologies	54.00	1,588	1,588	0	1,588	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			14,617,572	4,161,210	18,778,782	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2016 11:51 am
		Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,181,356	899,665	281,691	1,181,356	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	11,364	11,364	0	11,364	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	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,192,720	911,029	281,691	1,192,720	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	115,957	73,413	42,544	115,957	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	8,046	4,770	3,276	8,046	30.01
31.00	HRR adjustment (see instructions)	70.94	-256,107	-208,337	-47,770	-256,107	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-18,557	-14,878	-3,679	-18,557	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: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/30/2016 11:51 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		98,656	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		11,535,263	2.00
3.00	PPS payments		8,612,124	3.00
4.00	Outlier payment (see instructions)		38,350	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)		98,656	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		319,443	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)		319,443	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		319,443	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		220,787	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)		98,656	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)		8,650,474	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,869,994	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)		6,879,136	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)		6,879,136	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		6,879,136	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)		389,492	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		253,170	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		277,905	36.00
37.00	Subtotal (see instructions)		7,132,306	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)		7,132,306	40.00
40.01	Sequestration adjustment (see instructions)		142,646	40.01
41.00	Interim payments		6,887,472	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		102,188	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/30/2016 11:51 am
		Component CCN: 14S034	Title XVII I	Subprovider - IPF
		PPS		
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		481	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		157,043	2.00
3.00	PPS payments		74,875	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)		481	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,556	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)		1,556	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,556	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,075	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)		481	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)		74,875	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)		16,636	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)		58,720	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)		58,720	30.00
31.00	Primary payer payments		83	31.00
32.00	Subtotal (line 30 minus line 31)		58,637	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		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)		58,637	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)		58,637	40.00
40.01	Sequestration adjustment (see instructions)		1,173	40.01
41.00	Interim payments		57,531	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-67	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: 140034

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

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2016 11:51 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		16,306,623		6,722,980	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		210,285		92,759	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	08/27/2015	94,208	08/27/2015	71,733	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)		94,208		71,733	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)		16,611,116		6,887,472	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		130,030		102,188	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		16,741,146		6,989,660	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140034
Component CCN: 14S034

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

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2016 11:51 am
PPS

Title XVIII

Subprovider -
IPF

		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					1.00
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		449,944		57,531	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)		449,944		57,531	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		24,566		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		67	6.02
7.00	Total Medicare program liability (see instructions)		474,510		57,464	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/30/2016 11:51 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		3,980	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		10,324	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		798	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		16,031	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		242,913,642	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		2,241,828	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)		898,427	8.00
9.00	Sequestration adjustment amount (see instructions)		17,969	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		880,458	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		898,537	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)		-18,079	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part II Date/Time Prepared: 5/30/2016 11:51 am
		Component CCN: 14S034	Title XVII	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)		549,155	1.00
2.00	Net IPF PPS Outlier Payments		3,080	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		7.416438	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		552,235	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)		552,235	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		552,235	18.00
19.00	Deductibles		76,860	19.00
20.00	Subtotal (line 18 minus line 19)		475,375	20.00
21.00	Coinsurance		13,860	21.00
22.00	Subtotal (line 20 minus line 21)		461,515	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		34,890	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		22,679	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		30,351	25.00
26.00	Subtotal (sum of lines 22 and 24)		484,194	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)		484,194	31.00
31.01	Sequestration adjustment (see instructions)		9,684	31.01
32.00	Interim payments		449,944	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)		24,566	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		3,080	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

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

Provider CCN: 140034

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

Worksheet G

Date/Time Prepared:
5/30/2016 11:51 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	-9,858,943	0	0	0	1.00
2.00	Temporary investments	-144,270	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	27,876,959	0	0	0	4.00
5.00	Other receivable	970,919	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-12,845,805	0	0	0	6.00
7.00	Inventory	2,042,114	0	0	0	7.00
8.00	Prepaid expenses	101,760	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,142,734	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,259,000	0	0	0	12.00
13.00	Land improvements	667,527	0	0	0	13.00
14.00	Accumulated depreciation	-654,392	0	0	0	14.00
15.00	Buildings	28,829,089	0	0	0	15.00
16.00	Accumulated depreciation	-10,718,513	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,514,360	0	0	0	19.00
20.00	Accumulated depreciation	-1,030,721	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	20,764,688	0	0	0	23.00
24.00	Accumulated depreciation	-13,751,897	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)	27,879,141	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,750,031	210,247	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,750,031	210,247	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	37,771,906	210,247	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,068,198	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	421,929	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,770,927	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,261,054	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	42,064,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	7,889,289	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	49,953,289	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	55,214,343	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-17,442,437				52.00
53.00	Specific purpose fund		210,247			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)	-17,442,437	210,247	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	37,771,906	210,247	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140034

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

Worksheet G-1

Date/Time Prepared:
5/30/2016 11:51 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		-14,517,696		242,774		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,899,359				2.00
3.00	Total (sum of line 1 and line 2)		-11,618,337		242,774		3.00
4.00	ADDITIONS (OTHER)	0		26,983		0	4.00
5.00	GAIN ON INVESTMENTS	0		0		0	5.00
6.00	DONATIONS	0		0		0	6.00
7.00	TRANSFERS FROM OTHER FUNDS	45,881		2,846		0	7.00
8.00	CORPORATE OFFICE	15,142		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		61,023		29,829		10.00
11.00	Subtotal (line 3 plus line 10)		-11,557,314		272,603		11.00
12.00	DEDUCTIONS (OTHER)	5,079,474		62,356		0	12.00
13.00	CORPORATE OFFICE	0		0		0	13.00
14.00	TRANSFER TO OTHER RELATED ORGANIZATI	798,890		0		0	14.00
15.00	TRANSFER TO OTHER FUNDS	0		0		0	15.00
16.00	LOSS ON INVESTMENTS	6,758		0		0	16.00
17.00	TRANSFER DEBT TO CORP.	0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		5,885,122		62,356		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-17,442,436		210,247		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 (OTHER)		0				4.00
5.00	GAIN ON INVESTMENTS		0				5.00
6.00	DONATIONS		0				6.00
7.00	TRANSFERS FROM OTHER FUNDS		0				7.00
8.00	CORPORATE OFFICE		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 (OTHER)		0				12.00
13.00	CORPORATE OFFICE		0				13.00
14.00	TRANSFER TO OTHER RELATED ORGANIZATI		0				14.00
15.00	TRANSFER TO OTHER FUNDS		0				15.00
16.00	LOSS ON INVESTMENTS		0				16.00
17.00	TRANSFER DEBT TO CORP.		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: 140034

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/30/2016 11:51 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	12,657,891		12,657,891	1.00
2.00	SUBPROVIDER - IPF	1,918,183		1,918,183	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	14,576,074		14,576,074	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,414,546		3,414,546	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)	3,414,546		3,414,546	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	17,990,620		17,990,620	17.00
18.00	Ancillary services	68,504,466	139,970,627	208,475,093	18.00
19.00	Outpatient services	5,552,344	20,350,372	25,902,716	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (NON-REIMB/PRO FEES)	1,103,251	3,838,056	4,941,307	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	93,150,681	164,159,055	257,309,736	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		91,591,002		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)		91,591,002		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140034

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

Worksheet G-3

Date/Time Prepared:
5/30/2016 11:51 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	257,309,736	1.00
2.00	Less contractual allowances and discounts on patients' accounts	166,651,939	2.00
3.00	Net patient revenues (line 1 minus line 2)	90,657,797	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	91,591,002	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-933,205	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	160,243	6.00
7.00	Income from investments	1,736	7.00
8.00	Revenues from telephone and other miscellaneous communication services	32	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	5,649	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	311,021	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	9,015	21.00
22.00	Rental of hospital space	200,709	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER - REVENUE	3,330,055	24.00
25.00	Total other income (sum of lines 6-24)	4,018,460	25.00
26.00	Total (line 5 plus line 25)	3,085,255	26.00
27.00	OTHER - EXPENSES	185,896	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	185,896	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,899,359	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140034	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/30/2016 11:51 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,181,356	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		11,364	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)		44.85	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)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,192,720	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