

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: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/27/2016 10:42 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/27/2016 Time: 10:42 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SSM HEALTH GOOD SAMARITAN HOSPITAL (140046) 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	366,184	216,563	37,799	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	3,651	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	369,835	216,563	37,799	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 140046		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 5/27/2016 8:28 pm		
1.00			2.00		3.00			4.00			
Hospital and Hospital Health Care Complex Address:											1.00
1.00 Street: 1 GOOD SAMARITAN WAY			PO Box:		Zip Code: 62864		County: JEFFERSON				1.00
2.00 City: MT. VERNON			State: IL								2.00
Component Name			CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00			2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00 Hospital			SSM HEALTH GOOD SAMARITAN HOSPITAL	140046	99914	1	07/01/1966	N	P	P	3.00
4.00 Subprovider - IPF			GOOD SAMARITAN REHABILITATION UNIT	14T046	99914	5	01/01/1990	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											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.			5,657	1,055	0	6	205	293		24.00	

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	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.	149	57	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.				0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.						38.00
				Y/N	Y/N		
				1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)				N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)				N	N	40.00
				V	XVII	XIX	
				1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)				N	N	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	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	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.				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	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02

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	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	

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	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.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y			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)			N		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	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	2,480,102	2,015,016	0	

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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	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
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
		1.00	2.00	3.00
				Title XIX
				4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)				
155.00	Hospital	N	N	N
156.00	Subprovider - IPF	N	N	N
157.00	Subprovider - IRF	N	N	N
158.00	SUBPROVIDER			
159.00	SNF	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N
161.00	CMHC		N	N
161.10	CORF		N	N
161.20	OUTPATIENT PHYSICAL THERAPY		N	N
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140046		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 5/27/2016 8:28 pm		
							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: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/27/2016 8:28 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
		Y/N	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	3.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N			N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/12/2015		Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140046		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part II Date/Time Prepared: 5/27/2016 8:28 pm	
	Description	Part A		Part B			
		Y/N	Date	Y/N			
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N					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 - GOVERNMENT 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: 140046

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2016 8:28 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	99	36,189	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)		99	36,189	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	16	5,840	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		115	42,029	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	10	3,650		0	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)		125				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: 140046

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2016 8:28 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	15,395	4,059	26,219			1.00
2.00 HMO and other (see instructions)	1,255	1,118				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	15,395	4,059	26,219			7.00
8.00 INTENSIVE CARE UNIT	1,622	492	3,062			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		1,254	1,675			13.00
14.00 Total (see instructions)	17,017	5,805	30,956	0.00	904.00	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	1,954	195	2,588	0.00	16.00	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	920.00	27.00
28.00 Observation Bed Days		0	2,785			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			402			30.00
31.00 Employee discount days - IRF			31			31.00
32.00 Labor & delivery days (see instructions)	0	293	447			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: 140046

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2016 8:28 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,666	1,626	7,365	1.00
2.00 HMO and other (see instructions)			292	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	3,666	1,626	7,365	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	193	16	255	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: 140046		Period: From 01/01/2015 To 12/31/2015		Worksheet S-3 Part II Date/Time Prepared: 5/27/2016 8:28 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	49,774,884	0	49,774,884	1,912,199.07	26.03	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		66,173	0	66,173	886.00	74.69	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		5,731,097	-206,217	5,524,880	112,061.25	49.30	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		228,341	0	228,341	9,299.72	24.55	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		880,184	0	880,184	6,326.23	139.13	13.00
14.00	Home office salaries & wage-related costs		9,411,690	0	9,411,690	202,958.12	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)		22,629,029	0	22,629,029			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,155,974	0	1,155,974			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		33,732	0	33,732			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		8,060	0	8,060			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	206,217	206,217	28,357.21	7.27	26.00
27.00	Administrative & General	5.00	4,679,513	8,911	4,688,424	158,963.97	29.49	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	881,391	-517,327	364,064	9,604.00	37.91	29.00
30.00	Operation of Plant	7.00	0	517,327	517,327	5,921.46	87.36	30.00
31.00	Laundry & Linen Service	8.00	135,525	0	135,525	9,903.89	13.68	31.00
32.00	Housekeeping	9.00	1,237,613	0	1,237,613	94,518.72	13.09	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,575,271	-1,009,829	565,442	36,020.18	15.70	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,009,829	1,009,829	110,853.82	9.11	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	875,164	0	875,164	24,623.93	35.54	38.00
39.00	Central Services and Supply	14.00	210,382	-8,911	201,471	16,965.89	11.88	39.00
40.00	Pharmacy	15.00	2,982,366	0	2,982,366	100,859.12	29.57	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140046

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

Worksheet S-3
Part II
Date/Time Prepared:
5/27/2016 8:28 pm

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medi cal Records & Medi cal Records Li brary	16.00	629,728	0	629,728	35,449.71	17.76	41.00
42.00	Soci al Servi ce	17.00	7,467	0	7,467	305.00	24.48	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140046

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

Worksheet S-3
Part III
Date/Time Prepared:
5/27/2016 8:28 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	49,774,884	0	49,774,884	1,912,199.07	26.03	1.00
2.00	Excluded area salaries (see instructions)	5,731,097	-206,217	5,524,880	112,061.25	49.30	2.00
3.00	Subtotal salaries (line 1 minus line 2)	44,043,787	206,217	44,250,004	1,800,137.82	24.58	3.00
4.00	Subtotal other wages & related costs (see inst.)	10,520,215	0	10,520,215	218,584.07	48.13	4.00
5.00	Subtotal wage-related costs (see inst.)	22,662,761	0	22,662,761	0.00	51.22	5.00
6.00	Total (sum of lines 3 thru 5)	77,226,763	206,217	77,432,980	2,018,721.89	38.36	6.00
7.00	Total overhead cost (see instructions)	13,214,420	206,217	13,420,637	632,346.90	21.22	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part IV Date/Time Prepared: 5/27/2016 8:28 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			280,078 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			1,850,313 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)			14,582,589 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			291,634 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			109,215 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			7,913 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			137,172 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			1,421,578 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			2,975,416 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			92,289 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			193,023 22.00
23.00	Tuition Reimbursement			241,226 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			22,182,446 24.00
Part B - Other than Core Related Cost				
25.00	OTHER - NON-CORE			44,062 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part V Date/Time Prepared: 5/27/2016 8:28 pm
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			1.00
2.00	Hospital			2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)			5.00
6.00	Swing Beds - SNF			6.00
7.00	Swing Beds - NF			7.00
8.00	Hospital -Based SNF			8.00
9.00	Hospital -Based NF			9.00
10.00	Hospital -Based OLTC			10.00
11.00	Hospital -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital -Based Hospice			13.00
14.00	Hospital -Based Health Clinic RHC			14.00
15.00	Hospital -Based Health Clinic FQHC			15.00
16.00	Hospital -Based-CMHC			16.00
16.10	Hospital -Based-CMHC 10			16.10
16.20	Hospital -Based-CMHC 20			16.20
16.30	Hospital -Based-CMHC 30			16.30
16.40	Hospital -Based-CMHC 40			16.40
17.00	Renal Dialysis			17.00
18.00	Other			18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 140046

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

Worksheet S-10

Date/Time Prepared:
5/27/2016 8:28 pm

				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)			0.297519	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			11,419,768	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			4,600,008	5.00
6.00	Medicaid charges			99,741,983	6.00
7.00	Medicaid cost (line 1 times line 6)			29,675,135	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)			13,655,359	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)			13,655,359	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	4,732,854	882,790	5,615,644	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,408,114	262,647	1,670,761	21.00
22.00	Partial payment by patients approved for charity care	64,059	118,834	182,893	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,344,055	143,813	1,487,868	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)			5,491,547	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			880,114	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			4,611,433	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			1,371,989	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,859,857	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			16,515,216	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140046

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

Worksheet A
Date/Time Prepared:
5/27/2016 8:28 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT		15,207,700	15,207,700	-66,164	15,141,536	1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP		6,015,112	6,015,112	0	6,015,112	2.00	
3.00 00300 OTHER CAP REL COSTS		0	0	0	0	3.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	20,973,687	20,973,687	223,921	21,197,608	4.00	
5.04 00570 ADMIN TTING	0	0	0	0	0	5.04	
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.05	
5.06 00590 ADMIN STRATIVE & GENERAL	4,679,513	25,660,966	30,340,479	766,559	31,107,038	5.06	
6.00 00600 MAINTENANCE & REPAIRS	881,391	2,382,225	3,263,616	-2,384,418	879,198	6.00	
6.01 00601 BIOMEDICAL SERVICES	0	1,372,388	1,372,388	0	1,372,388	6.01	
7.00 00700 OPERATION OF PLANT	0	0	0	2,384,631	2,384,631	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	135,525	415,910	551,435	0	551,435	8.00	
9.00 00900 HOUSEKEEPING	1,237,613	710,252	1,947,865	-213,233	1,734,632	9.00	
10.00 01000 DIETARY	1,575,271	1,086,660	2,661,931	-1,760,760	901,171	10.00	
11.00 01100 CAFETERIA	0	0	0	1,780,653	1,780,653	11.00	
13.00 01300 NURSING ADMINISTRATION	875,164	64,395	939,559	0	939,559	13.00	
14.00 01400 CENTRAL SERVICE & SUPPLY	210,382	82,341	292,723	25,175	317,898	14.00	
15.00 01500 PHARMACY	2,982,366	6,161,270	9,143,636	-5,635,353	3,508,283	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	629,728	293,387	923,115	0	923,115	16.00	
17.00 01700 SOCIAL SERVICE	7,467	2,601	10,068	0	10,068	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	11,879,169	1,636,914	13,516,083	-3,008,623	10,507,460	30.00	
31.00 03100 INTENSIVE CARE UNIT	2,594,676	523,698	3,118,374	-460,034	2,658,340	31.00	
41.00 04100 SUBPROVIDER - IIRF	911,460	45,983	957,443	-8,912	948,531	41.00	
43.00 04300 NURSERY	0	0	0	993,866	993,866	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	3,667,914	9,728,331	13,396,245	-8,297,148	5,099,097	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	831,786	831,786	52.00	
53.00 05300 ANESTHESIOLOGY	42	900,005	900,047	-260,864	639,183	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,842,920	899,612	2,742,532	-282,514	2,460,018	54.00	
57.00 05700 CT SCAN	450,224	114,973	565,197	-52,132	513,065	57.00	
58.00 05800 MRI	200,384	77,185	277,569	-71,253	206,316	58.00	
59.00 05900 CARDIAC CATHETERIZATION	851,614	3,009,389	3,861,003	-2,979,251	881,752	59.00	
60.00 06000 LABORATORY	1,772,841	3,533,721	5,306,562	-161,278	5,145,284	60.00	
64.00 06400 INTRAVENOUS THERAPY	234,684	43,287	277,971	-42,117	235,854	64.00	
65.00 06500 RESPIRATORY THERAPY	1,218,935	276,100	1,495,035	-145,867	1,349,168	65.00	
66.00 06600 PHYSICAL THERAPY	1,134,891	33,721	1,168,612	-8,440	1,160,172	66.00	
67.00 06700 OCCUPATIONAL THERAPY	420,019	10,127	430,146	-7,712	422,434	67.00	
68.00 06800 SPEECH PATHOLOGY	272,185	10,551	282,736	-2,443	280,293	68.00	
69.00 06900 ELECTROCARDIOLOGY	630,997	881,659	1,512,656	-29,945	1,482,711	69.00	
70.01 07001 NEUROLOGY	72,259	40,100	112,359	-1,694	110,665	70.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	8,133,473	8,133,473	71.00	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	6,272,800	6,272,800	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	5,635,353	5,635,353	73.00	
76.00 03950 ACUTE DIALYSIS	22,202	907,466	929,668	-21,759	907,909	76.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	169,528	76,241	245,769	-27,437	218,332	90.00	
90.01 09001 DIABETES EDUCATION	22,750	753	23,503	0	23,503	90.01	
90.04 09005 ANTI COAGULATION CLINIC	108,382	270	108,652	0	108,652	90.04	
90.05 09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05	
91.00 09100 EMERGENCY	3,262,751	1,564,246	4,826,997	-362,502	4,464,495	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	3,089	3,089	0	3,089	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)	44,955,247	104,746,315	149,701,562	756,364	150,457,926	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	51,394	10,834	62,228	0	62,228	190.00	
192.00 19200 PHYSICIANS PRIVATE OFFICES	4,158,948	4,963,047	9,121,995	-578,714	8,543,281	192.00	
192.08 19208 FOUNDATION	0	0	0	0	0	192.08	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
193.05 19305 NON-REIMBURSABLE DEPT	0	696	696	0	696	193.05	
193.06 19306 OUTSIDE ACCOUNTING	0	0	0	0	0	193.06	
194.00 07950 CHILD CARE	312,261	46,701	358,962	-177,650	181,312	194.00	
194.10 07951 RETAIL PHARMACY	276,667	1,088,643	1,365,310	0	1,365,310	194.10	
194.20 07952 OTHER NON-REIMBURSABLE	20,367	3,556	23,923	0	23,923	194.20	
200.00	TOTAL (SUM OF LINES 118-199)	49,774,884	110,859,792	160,634,676	0	160,634,676	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140046

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

Worksheet A
Date/Time Prepared:
5/27/2016 8:28 pm

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	-5,675,660	9,465,876	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,279,914	7,295,026	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,972,437	17,225,171	4.00
5.04	00570	ADMINISTRATIVE	0	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	-4,185,077	26,921,961	5.06
6.00	00600	MAINTENANCE & REPAIRS	-167,371	711,827	6.00
6.01	00601	BIOMEDICAL SERVICES	-396	1,371,992	6.01
7.00	00700	OPERATION OF PLANT	0	2,384,631	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	551,435	8.00
9.00	00900	HOUSEKEEPING	-2,596	1,732,036	9.00
10.00	01000	DIETARY	-217,388	683,783	10.00
11.00	01100	CAFETERIA	-530,510	1,250,143	11.00
13.00	01300	NURSING ADMINISTRATION	-12,109	927,450	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	317,898	14.00
15.00	01500	PHARMACY	-6,937	3,501,346	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,290	913,825	16.00
17.00	01700	SOCIAL SERVICE	-6,185	3,883	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,955	10,504,505	30.00
31.00	03100	INTENSIVE CARE UNIT	-12,107	2,646,233	31.00
41.00	04100	SUBPROVIDER - I RF	-261	948,270	41.00
43.00	04300	NURSERY	0	993,866	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-2,211	5,096,886	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	831,786	52.00
53.00	05300	ANESTHESIOLOGY	-499,413	139,770	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-46,997	2,413,021	54.00
57.00	05700	CT SCAN	0	513,065	57.00
58.00	05800	MRI	0	206,316	58.00
59.00	05900	CARDIAC CATHETERIZATION	-300	881,452	59.00
60.00	06000	LABORATORY	-69,026	5,076,258	60.00
64.00	06400	INTRAVENOUS THERAPY	0	235,854	64.00
65.00	06500	RESPIRATORY THERAPY	-11,337	1,337,831	65.00
66.00	06600	PHYSICAL THERAPY	-6,266	1,153,906	66.00
67.00	06700	OCCUPATIONAL THERAPY	-40	422,394	67.00
68.00	06800	SPEECH PATHOLOGY	0	280,293	68.00
69.00	06900	ELECTROCARDIOLOGY	-647,810	834,901	69.00
70.01	07001	NEUROLOGY	-18,563	92,102	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	8,133,473	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	6,272,800	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-85,830	5,549,523	73.00
76.00	03950	ACUTE DIALYSIS	-10,928	896,981	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-92	218,240	90.00
90.01	09001	DIABETES EDUCATION	0	23,503	90.01
90.04	09005	ANTI COAGULATION CLINIC	0	108,652	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	90.05
91.00	09100	EMERGENCY	-1,132,044	3,332,451	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	3,089	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-16,052,222	134,405,704	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	62,228	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	8,543,281	192.00
192.08	19208	FOUNDATION	0	0	192.08
193.00	19300	NONPAID WORKERS	0	0	193.00
193.05	19305	NON-REIMBURSABLE DEPT	0	696	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	0	193.06
194.00	07950	CHILD CARE	0	181,312	194.00
194.10	07951	RETAIL PHARMACY	0	1,365,310	194.10
194.20	07952	OTHER NON-REIMBURSABLE	0	23,923	194.20
200.00		TOTAL (SUM OF LINES 118-199)	-16,052,222	144,582,454	200.00

RECLASSIFICATIONS

Provider CCN: 140046

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 - OBSTETRICS UNIT COST					
1.00	NURSERY	43.00	836,719	157,147	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	700,076	131,710	2.00
	O		1,536,795	288,857	
B - PLANT OPERATIONS					
1.00	OPERATION OF PLANT	7.00	517,327	1,867,304	1.00
	O		517,327	1,867,304	
E - SHARED DIETARY COST					
1.00	CAFETERIA	11.00	1,009,829	770,824	1.00
	O		1,009,829	770,824	
F - MAILROOM COST					
1.00	ADMINISTRATIVE & GENERAL	5.06	8,911	0	1.00
	O		8,911	0	
G - CHILD CARE DIETARY					
1.00	DIETARY	10.00	0	19,893	1.00
	O		0	19,893	
H - EMPLOYEE CHILD CARE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	206,217	17,704	1.00
	O		206,217	17,704	
J - INVENTORY COST					
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	34,086	1.00
	O		0	34,086	
K - DOCUMENT SHREDDING COST					
1.00	ADMINISTRATIVE & GENERAL	5.06	0	213,233	1.00
	O		0	213,233	
L - MEDICAL PLAZA EXPENSES					
1.00	ADMINISTRATIVE & GENERAL	5.06	0	578,501	1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	213	2.00
	O		0	578,714	
M - CHILD CARE DEPRECIATION					
1.00	CHILD CARE	194.00	0	66,164	1.00
	O		0	66,164	
N - C. SUPPLIES-CHARGEABLE IMPLANTABLES					
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	6,272,800	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
	TOTALS		0	6,272,800	
O - C SUPPLIES-CHARGEABLE MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	8,133,473	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
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	8,133,473	
P - PHARM-DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,635,353	1.00
	TOTALS		0	5,635,353	
500.00	Grand Total: Increases		3,279,079	23,898,405	500.00

RECLASSIFICATIONS

Provider CCN: 140046

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

Worksheet A-6
Date/Time Prepared:
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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - OBSTETRICS UNIT COST							
1.00	ADULTS & PEDIATRICS	30.00	836,719	157,147	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	700,076	131,710	0		2.00
	O		1,536,795	288,857			
B - PLANT OPERATIONS							
1.00	MAINTENANCE & REPAIRS	6.00	517,327	1,867,304	0		1.00
	O		517,327	1,867,304			
E - SHARED DIETARY COST							
1.00	DIETARY	10.00	1,009,829	770,824	0		1.00
	O		1,009,829	770,824			
F - MAILROOM COST							
1.00	CENTRAL SERVICE & SUPPLY	14.00	8,911	0	0		1.00
	O		8,911	0			
G - CHILD CARE DIETARY							
1.00	CHILD CARE	194.00	0	19,893	0		1.00
	O		0	19,893			
H - EMPLOYEE CHILD CARE							
1.00	CHILD CARE	194.00	206,217	17,704	0		1.00
	O		206,217	17,704			
J - INVENTORY COST							
1.00	ADMINISTRATIVE & GENERAL	5.06	0	34,086	0		1.00
	O		0	34,086			
K - DOCUMENT SHREDDING COST							
1.00	HOUSEKEEPING	9.00	0	213,233	0		1.00
	O		0	213,233			
L - MEDICAL PLAZA EXPENSES							
1.00	PHYSICIANS PRIVATE OFFICES	192.00	0	578,714	0		1.00
2.00		0.00	0	0	0		2.00
	O		0	578,714			
M - CHILD CARE DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	66,164	9		1.00
	O		0	66,164			
N - C. SUPPLIES-CHARGEABLE IMPLANTABLES							
1.00	ADULTS & PEDIATRICS	30.00	0	2,418	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	327	0		2.00
3.00	OPERATING ROOM	50.00	0	4,336,958	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	1,346	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,732	0		5.00
6.00	CARDIAC CATHETERIZATION	59.00	0	1,915,464	0		6.00
7.00	LABORATORY	60.00	0	2,873	0		7.00
8.00	ELECTROCARDIOLOGY	69.00	0	23	0		8.00
9.00	EMERGENCY	91.00	0	659	0		9.00
	TOTALS		0	6,272,800			
O - C SUPPLIES-CHARGEABLE MED SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	1,180,553	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	459,707	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	8,912	0		3.00
4.00	OPERATING ROOM	50.00	0	3,960,190	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	259,518	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	269,782	0		6.00
7.00	CT SCAN	57.00	0	52,132	0		7.00
8.00	MRI	58.00	0	71,253	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	1,063,787	0		9.00
10.00	LABORATORY	60.00	0	158,405	0		10.00
11.00	INTRAVENOUS THERAPY	64.00	0	42,117	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	145,867	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	8,440	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	7,712	0		14.00
15.00	SPEECH PATHOLOGY	68.00	0	2,443	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	29,922	0		16.00
17.00	NEUROLOGY	70.01	0	1,694	0		17.00
20.00	ACUTE DIALYSIS	76.00	0	21,759	0		20.00
21.00	CLINIC	90.00	0	27,437	0		21.00
22.00	EMERGENCY	91.00	0	361,843	0		22.00
	TOTALS		0	8,133,473			
P - PHARM-DRUGS CHARGED TO PATIENTS							
1.00	PHARMACY	15.00	0	5,635,353	0		1.00
	TOTALS		0	5,635,353			
500.00	Grand Total: Decreases		3,279,079	23,898,405			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140046

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	632,759	0	0	0	1.00
2.00	Land Improvements	6,613,257	0	0	0	2.00
3.00	Buildings and Fixtures	155,527,055	860,295	0	860,295	3.00
4.00	Building Improvements	18,021,877	4,297	0	4,297	4.00
5.00	Fixed Equipment	13,770,680	765,396	0	765,396	5.00
6.00	Movable Equipment	57,139,558	3,397,927	0	3,397,927	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	251,705,186	5,027,915	0	5,027,915	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	251,705,186	5,027,915	0	5,027,915	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	632,759	0			1.00
2.00	Land Improvements	6,613,257	0			2.00
3.00	Buildings and Fixtures	156,387,350	0			3.00
4.00	Building Improvements	17,273,279	0			4.00
5.00	Fixed Equipment	14,487,858	0			5.00
6.00	Movable Equipment	57,270,796	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	252,665,299	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	252,665,299	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140046

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	7,884,604	0	7,323,096	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,015,112	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	13,899,716	0	7,323,096	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	15,207,700				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,015,112				2.00
3.00	Total (sum of lines 1-2)	0	21,222,812				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140046

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	188,148,487	0	188,148,487	0.859095	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	44,064,998	13,205,798	30,859,200	0.140905	0	2.00
3.00	Total (sum of lines 1-2)	232,213,485	13,205,798	219,007,687	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	8,018,608	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	7,295,026	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	15,313,634	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	1,447,268	0	0	0	9,465,876	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	7,295,026	2.00
3.00	Total (sum of lines 1-2)	1,447,268	0	0	0	16,760,902	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140046

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 #	
			1.00	2.00	3.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-263,162	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,654,514			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-32,287	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-10,691,597			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-217,214	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	B	-6,456	PHARMACY	15.00	0	17.00
18.00 Sale of medical records and abstracts	B	-9,148	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines	B	-530,510	CAFETERIA	11.00	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	B	-23,242	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	B	83,970	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00		0		0.00	0	33.00
33.02		0		0.00	0	33.02

ADJUSTMENTS TO EXPENSES

Provider CCN: 140046

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 #	
			1.00	2.00	3.00	
34.00 RENT REVENUE	B	-58,746	MAINTENANCE & REPAIRS	6.00	0	34.00
35.00		0		0.00	0	35.00
36.00 RENT REVENUE	B	-108,309	MAINTENANCE & REPAIRS	6.00	0	36.00
36.50		0		0.00	0	36.50
37.00		0		0.00	0	37.00
38.00 VENDING COMMISSIONS AND RECYCLI	B	-2,296	HOUSEKEEPING	9.00	0	38.00
39.00 SOCIAL SERVICES REVENUE	B	-6,160	SOCIAL SERVICE	17.00	0	39.00
40.00 A&P REVENUE	B	-1,615	ADULTS & PEDIATRICS	30.00	0	40.00
40.05		0		0.00	0	40.05
41.00		0		0.00	0	41.00
41.01 CARDIAC EXERCISE	B	-14,015	ELECTROCARDIOLOGY	69.00	0	41.01
41.20		0		0.00	0	41.20
41.40		0		0.00	0	41.40
42.00 MANAGEMENT FEE	B	-13,526	NEUROLOGY	70.01	0	42.00
44.00		0		0.00	0	44.00
45.00		0		0.00	0	45.00
45.01 NON-PATIENT TELEPHONE COST	A	-26,743	ADMINISTRATIVE & GENERAL	5.06	0	45.01
45.02 NON-PATIENT TELEPHONE DEPR	A	5,537	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.02
45.03 EMPLOYEE CHILD CARE	A	-210,766	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.03
45.04 REAL ESTATE TAXES	A	-360	ADMINISTRATIVE & GENERAL	5.06	0	45.04
45.05 ADVERTISING	A	-16,947	ADMINISTRATIVE & GENERAL	5.06	0	45.05
45.06 PHYSICIAN RECRUITMENT	A	-380,780	ADMINISTRATIVE & GENERAL	5.06	0	45.06
45.07 ADVERTISING	A	-167	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.07
45.08 LOBBYING DUES	A	-6,038	ADMINISTRATIVE & GENERAL	5.06	0	45.08
45.09 MGMT - CLAY	A	-618,809	ADMINISTRATIVE & GENERAL	5.06	0	45.09
45.10 GIFTS & ENTERTAINMENT	A	-316	MAINTENANCE & REPAIRS	6.00	0	45.10
45.11 GIFTS & ENTERTAINMENT	A	-10,832	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.11
45.12 GIFTS & ENTERTAINMENT	A	-165,230	ADMINISTRATIVE & GENERAL	5.06	0	45.12
45.13 NON-PATIENT TELEPHONE (SALARY)	A	-21,756	ADMINISTRATIVE & GENERAL	5.06	0	45.13
45.14 NON-PATIENT TELEPHONE (BENEFITS	A	-9,204	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.14
45.15 GIFTS & ENTERTAINMENT	A	-300	HOUSEKEEPING	9.00	0	45.15
45.16		0		0.00	0	45.16
45.17 GIFTS & ENTERTAINMENT	A	-174	DIETARY	10.00	0	45.17
45.18 GIFTS & ENTERTAINMENT	A	-109	NURSING ADMINISTRATION	13.00	0	45.18
45.19 GIFTS & ENTERTAINMENT	A	-25	SOCIAL SERVICE	17.00	0	45.19
45.20 PERSONAL USE (DUES)	A	-750	ADMINISTRATIVE & GENERAL	5.06	0	45.20
45.21 GIFTS & ENTERTAINMENT	A	-1,340	ADULTS & PEDIATRICS	30.00	0	45.21
45.22 GIFTS & ENTERTAINMENT	A	-343	INTENSIVE CARE UNIT	31.00	0	45.22
45.23 GIFTS & ENTERTAINMENT	A	-1,800	OPERATING ROOM	50.00	0	45.23
45.24 GIFTS & ENTERTAINMENT	A	-717	LABORATORY	60.00	0	45.24
45.25 GIFTS & ENTERTAINMENT	A	-266	PHYSICAL THERAPY	66.00	0	45.25
45.26 ADVERTISING	A	-411	OPERATING ROOM	50.00	0	45.26
45.27 GIFTS & ENTERTAINMENT	A	-40	OCCUPATIONAL THERAPY	67.00	0	45.27
45.28 ADVERTISING	A	-92	CLINIC	90.00	0	45.28
45.29 ADVERTISING (SUB)	A	-177	PHARMACY	15.00	0	45.29
45.30 MD RECRUITMENT	A	-12,000	NURSING ADMINISTRATION	13.00	0	45.30
45.31		0		0.00	0	45.31
45.32 GIFTS & ENTERTAINMENT	A	-304	PHARMACY	15.00	0	45.32
45.33 GIFTS & ENTERTAINMENT	A	-1,103	EMERGENCY	91.00	0	45.33
45.34 MD RECRUITMENT	A	-14,733	LABORATORY	60.00	0	45.34
45.35 GIFTS & ENTERTAINMENT	A	-300	CARDIAC CATHETERIZATION	59.00	0	45.35
45.36 MD RECRUITMENT	A	-6,000	PHYSICAL THERAPY	66.00	0	45.36
45.75		0		0.00	0	45.75
46.00		0		0.00	0	46.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-16,052,222				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: 140046

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

Worksheet A-8-1

Date/Time Prepared: 5/27/2016 8:28 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	223,410	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1,190,407	0
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE - INTEREST	0	5,612,666
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	12,962,753	16,704,221
4.01	5.06	ADMINISTRATIVE & GENERAL	HOME OFFICE	12,693,785	15,358,839
4.02	6.01	BIOMEDICAL SERVICES	HOME OFFICE	0	396
4.03	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	-85,830	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			26,984,525	37,676,122

* 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	SSM	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				0.00	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.

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

Provider CCN: 140046

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

Worksheet A-8-1

Date/Time Prepared:
5/27/2016 8:28 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	223,410	9		1.00
2.00	1,190,407	9		2.00
3.00	-5,612,666	11		3.00
4.00	-3,741,468	0		4.00
4.01	-2,665,054	0		4.01
4.02	-396	0		4.02
4.03	-85,830	0		4.03
5.00	-10,691,597			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	CORPORATE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140046

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

Worksheet A-8-2

Date/Time Prepared:
5/27/2016 8:28 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.06	ADMINISTRATIVE & GENERAL	525,121	118,943	406,178	179,000	2,818	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	142	142	0	179,000	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	22,263	0	22,263	179,000	122	3.00
4.00	41.00	SUBPROVIDER - IRF	57,489	0	57,489	179,000	665	4.00
5.00	53.00	ANESTHESIOLOGY	551,897	477,517	74,380	239,400	456	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	41,900	0	41,900	271,900	208	6.00
7.00	60.00	LABORATORY	99,129	13,208	85,921	260,300	364	7.00
8.00	65.00	RESPIRATORY THERAPY	17,619	4,253	13,366	179,000	73	8.00
9.00	69.00	ELECTROCARDIOLOGY	838,182	595,188	242,994	179,000	2,375	9.00
10.00	70.01	NEUROLOGY	10,200	0	10,200	179,000	60	10.00
11.00	76.00	ACUTE DIALYSIS	22,202	0	22,202	179,000	131	11.00
12.00	91.00	EMERGENCY	1,130,941	1,130,941	0	179,000	0	12.00
200.00			3,317,085	2,340,192	976,893		7,272	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	5.06	ADMINISTRATIVE & GENERAL	242,511	12,126	0	0	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	10,499	525	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	57,228	2,861	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	52,484	2,624	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	27,190	1,360	0	0	0	6.00
7.00	60.00	LABORATORY	45,553	2,278	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	6,282	314	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	204,387	10,219	0	0	0	9.00
10.00	70.01	NEUROLOGY	5,163	258	0	0	0	10.00
11.00	76.00	ACUTE DIALYSIS	11,274	564	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
200.00			662,571	33,129	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	5.06	ADMINISTRATIVE & GENERAL	0	242,511	163,667	282,610	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	0	0	0	142	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	10,499	11,764	11,764	3.00
4.00	41.00	SUBPROVIDER - IRF	0	57,228	261	261	4.00
5.00	53.00	ANESTHESIOLOGY	0	52,484	21,896	499,413	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	27,190	14,710	14,710	6.00
7.00	60.00	LABORATORY	0	45,553	40,368	53,576	7.00
8.00	65.00	RESPIRATORY THERAPY	0	6,282	7,084	11,337	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	204,387	38,607	633,795	9.00
10.00	70.01	NEUROLOGY	0	5,163	5,037	5,037	10.00
11.00	76.00	ACUTE DIALYSIS	0	11,274	10,928	10,928	11.00
12.00	91.00	EMERGENCY	0	0	0	1,130,941	12.00
200.00			0	662,571	314,322	2,654,514	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140046

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2016 8:28 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.04	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	9,465,876	9,465,876			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	7,295,026		7,295,026		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	17,225,171	233,144	0	17,458,315	4.00
5.04 00570	ADMITTING	0	54,617	0	0	54,617 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	2,527	0	0 5.05
5.06 00590	ADMINISTRATIVE & GENERAL	26,921,961	1,188,900	1,572,320	1,769,282	0 5.06
6.00 00600	MAINTENANCE & REPAIRS	711,827	1,109,022	617,692	137,423	0 6.00
6.01 00601	BIO MEDICAL SERVICES	1,371,992	6,393	2,298	0	0 6.01
7.00 00700	OPERATION OF PLANT	2,384,631	361,318	29,824	195,275	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	551,435	101,811	1,368	51,156	0 8.00
9.00 00900	HOUSEKEEPING	1,732,036	237,407	41,403	467,161	0 9.00
10.00 01000	DIETARY	683,783	91,658	4,736	213,436	0 10.00
11.00 01100	CAFETERIA	1,250,143	239,418	11,569	381,179	0 11.00
13.00 01300	NURSING ADMINISTRATION	927,450	45,422	502,567	330,347	0 13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	317,898	0	0	0	0 14.00
15.00 01500	PHARMACY	3,501,346	80,883	28,971	1,125,753	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	913,825	97,070	3,782	237,703	0 16.00
17.00 01700	SOCIAL SERVICE	3,883	80,931	0	2,819	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	10,504,505	1,342,120	82,264	3,903,959	3,842 30.00
31.00 03100	INTENSIVE CARE UNIT	2,646,233	419,334	158,769	979,410	654 31.00
41.00 04100	SUBPROVIDER - I R F	948,270	216,168	0	344,048	238 41.00
43.00 04300	NURSERY	993,866	25,644	37,768	315,835	109 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,096,886	752,422	935,112	1,412,020	8,217 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	831,786	231,301	31,601	264,257	791 52.00
53.00 05300	ANESTHESIOLOGY	139,770	6,130	52,759	16	1,244 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,413,021	536,134	967,340	698,490	4,160 54.00
57.00 05700	CT SCAN	513,065	92,353	196,498	169,993	5,542 57.00
58.00 05800	MRI	206,316	51,983	15,293	75,639	1,300 58.00
59.00 05900	CARDIAC CATHETERIZATION	881,452	157,672	117,792	366,280	2,776 59.00
60.00 06000	LABORATORY	5,076,258	212,744	241,859	669,193	8,207 60.00
64.00 06400	INTRAVENOUS THERAPY	235,854	32,420	2,529	88,586	205 64.00
65.00 06500	RESPIRATORY THERAPY	1,337,831	35,246	98,820	461,021	1,671 65.00
66.00 06600	PHYSICAL THERAPY	1,153,906	89,551	9,062	428,386	837 66.00
67.00 06700	OCCUPATIONAL THERAPY	422,394	82,440	849	158,544	341 67.00
68.00 06800	SPEECH PATHOLOGY	280,293	16,306	1,085	102,741	100 68.00
69.00 06900	ELECTROCARDIOLOGY	834,901	419,502	155,137	237,594	1,895 69.00
70.01 07001	NEUROLOGY	92,102	31,103	15,578	27,276	55 70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	8,133,473	0	0	0	412 71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	6,272,800	0	0	0	2,308 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	5,549,523	0	0	0	5,991 73.00
76.00 03950	ACUTE DIALYSIS	896,981	25,381	7,915	8,381	261 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	218,240	51,767	6,837	63,992	74 90.00
90.01 09001	DIABETES EDUCATION	23,503	0	0	8,587	6 90.01
90.04 09005	ANTI COAGULATION CLINIC	108,652	24,255	0	40,911	129 90.04
90.05 09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	2,957 90.05
91.00 09100	EMERGENCY	3,332,451	373,146	107,188	1,231,587	295 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					
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	3,089	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)	134,405,704	9,153,116	6,061,112	16,968,280	54,617 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	62,228	34,073	1,478	19,400	0 190.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	8,543,281	0	1,210,254	318,486	0 192.00
192.08 19208	FOUNDATION	0	8,644	0	0	0 192.08
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.05 19305	NON-REIMBURSABLE DEPT	696	0	0	0	0 193.05
193.06 19306	OUTSIDE ACCOUNTING	0	0	0	0	0 193.06
194.00 07950	CHILD CARE	181,312	238,245	1,809	40,028	0 194.00
194.10 07951	RETAIL PHARMACY	1,365,310	31,798	20,373	104,433	0 194.10
194.20 07952	OTHER NON-REIMBURSABLE	23,923	0	0	7,688	0 194.20

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140046

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2016 8:28 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.04	
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0		0 201.00
202.00 TOTAL (sum lines 118-201)	144,582,454	9,465,876	7,295,026	17,458,315	54,617	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140046

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2016 8:28 pm

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	BIOMEDICAL SERVICES	
			5.05	5A.05	5.06	6.00	6.01	
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
5.04	00570	ADMINISTRATIVE						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,527					5.05
5.06	00590	ADMINISTRATIVE & GENERAL	0	31,452,463	31,452,463			5.06
6.00	00600	MAINTENANCE & REPAIRS	0	2,575,964	716,172	3,292,136		6.00
6.01	00601	BIOMEDICAL SERVICES	0	1,380,683	383,859	1,112	1,765,654	6.01
7.00	00700	OPERATION OF PLANT	0	2,971,048	826,014	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	705,770	196,219	40,589	0	8.00
9.00	00900	HOUSEKEEPING	0	2,478,007	688,938	77,841	0	9.00
10.00	01000	DIETARY	0	993,613	276,245	116,206	0	10.00
11.00	01100	CAFETERIA	0	1,882,309	523,321	283,565	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,805,786	502,046	2,224	94,008	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	317,898	88,382	0	0	14.00
15.00	01500	PHARMACY	0	4,736,953	1,316,972	83,958	52,371	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,252,380	348,188	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	87,633	24,364	1,112	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	179	15,836,869	4,402,934	989,143	156,137	30.00
31.00	03100	INTENSIVE CARE UNIT	30	4,204,430	1,168,920	140,115	33,830	31.00
41.00	04100	SUBPROVIDER - I RF	11	1,508,735	419,460	55,045	0	41.00
43.00	04300	NURSERY	5	1,373,227	381,786	60,605	22,445	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	365	8,205,022	2,281,168	347,506	206,882	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	37	1,359,773	378,045	50,597	19,517	52.00
53.00	05300	ANESTHESIOLOGY	58	199,977	55,598	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	196	4,619,341	1,284,274	27,801	282,999	54.00
57.00	05700	CT SCAN	258	977,709	271,824	6,672	1,301	57.00
58.00	05800	MRI	60	350,591	97,472	1,112	56,600	58.00
59.00	05900	CARDIAC CATHETERIZATION	129	1,526,101	424,288	48,929	495,412	59.00
60.00	06000	LABORATORY	382	6,208,643	1,726,133	15,012	45,215	60.00
64.00	06400	INTRAVENOUS THERAPY	10	359,604	99,977	33,917	0	64.00
65.00	06500	RESPIRATORY THERAPY	78	1,934,667	537,878	13,900	109,296	65.00
66.00	06600	PHYSICAL THERAPY	39	1,681,781	467,570	0	13,337	66.00
67.00	06700	OCCUPATIONAL THERAPY	16	664,584	184,768	0	4,554	67.00
68.00	06800	SPEECH PATHOLOGY	5	400,530	111,356	0	2,277	68.00
69.00	06900	ELECTROCARDIOLOGY	88	1,649,117	458,489	180,147	107,344	69.00
70.01	07001	NEUROLOGY	3	166,117	46,184	0	15,288	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	19	8,133,904	2,261,396	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	107	6,275,215	1,744,642	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	279	5,555,793	1,544,627	0	0	73.00
76.00	03950	ACUTE DIALYSIS	12	938,931	261,043	25,576	3,903	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3	340,913	94,781	0	0	90.00
90.01	09001	DIABETES EDUCATION	0	32,096	8,923	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	6	173,953	48,363	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	138	3,095	860	0	0	90.05
91.00	09100	EMERGENCY	14	5,044,681	1,402,527	289,681	38,384	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)		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	3,089	859	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)	2,527	132,368,995	28,056,865	2,892,365	1,761,100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	117,179	32,578	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	10,072,021	2,800,233	391,987	4,554	192.00
192.08	19208	FOUNDATION	0	8,644	2,403	556	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.05	19305	NON-REIMBURSABLE DEPT	0	696	194	0	0	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
194.00	07950	CHILD CARE	0	461,394	128,277	7,228	0	194.00
194.10	07951	RETAIL PHARMACY	0	1,521,914	423,124	0	0	194.10
194.20	07952	OTHER NON-REIMBURSABLE	0	31,611	8,789	0	0	194.20
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)	2,527	144,582,454	31,452,463	3,292,136	1,765,654	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140046

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

Worksheet B
Part I
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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.04	00570	ADMINISTRATIVE					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	BIO MEDICAL SERVICES					6.01
7.00	00700	OPERATION OF PLANT	3,797,062				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	59,360	1,001,938			8.00
9.00	00900	HOUSEKEEPING	138,418	5,010	3,388,214		9.00
10.00	01000	DIETARY	53,441	2,037	50,307	1,491,849	10.00
11.00	01100	CAFETERIA	139,591	4,976	131,406	0	2,965,168
13.00	01300	NURSING ADMINISTRATION	26,483	0	24,930	0	50,116
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	47,159	32,362	44,393	0	200,462
16.00	01600	MEDICAL RECORDS & LIBRARY	56,596	0	53,277	0	70,997
17.00	01700	SOCIAL SERVICE	47,187	0	44,420	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	782,512	470,511	736,627	1,097,453	868,670
31.00	03100	INTENSIVE CARE UNIT	244,490	96,888	230,154	63,543	183,757
41.00	04100	SUBPROVIDER - IRF	126,035	50,097	118,645	72,203	66,821
43.00	04300	NURSERY	14,952	15,029	14,075	0	58,468
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	438,695	83,461	412,971	60,128	271,459
52.00	05200	DELIVERY ROOM & LABOR ROOM	134,858	0	126,951	0	45,939
53.00	05300	ANESTHESIOLOGY	3,574	0	3,364	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	312,590	91,277	294,260	0	141,994
57.00	05700	CT SCAN	53,846	0	50,675	0	37,587
58.00	05800	MRI	30,308	20,038	28,531	0	12,529
59.00	05900	CARDIAC CATHETERIZATION	91,930	10,019	86,539	0	75,173
60.00	06000	LABORATORY	124,039	0	116,766	0	175,404
64.00	06400	INTRAVENOUS THERAPY	18,903	0	17,794	0	16,705
65.00	06500	RESPIRATORY THERAPY	20,550	0	19,345	0	108,584
66.00	06600	PHYSICAL THERAPY	52,212	0	49,151	0	83,526
67.00	06700	OCCUPATIONAL THERAPY	48,066	0	45,248	0	29,234
68.00	06800	SPEECH PATHOLOGY	9,507	0	8,950	0	16,705
69.00	06900	ELECTROCARDIOLOGY	244,588	5,010	230,246	0	54,292
70.01	07001	NEUROLOGY	18,135	2,505	17,071	0	4,176
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03950	ACUTE DIALYSIS	14,798	2,204	13,930	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	30,183	0	28,413	0	12,529
90.01	09001	DIABETES EDUCATION	0	0	0	0	4,176
90.04	09005	ANTI COAGULATION CLINIC	14,142	0	13,313	0	4,176
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0
91.00	09100	EMERGENCY	217,561	103,500	204,803	23,146	233,872
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,614,709	994,924	3,216,555	1,316,473	2,827,351
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	19,866	0	18,701	0	8,353
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	91,878
192.08	19208	FOUNDATION	5,040	0	4,744	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.05	19305	NON-REIMBURSABLE DEPT	0	0	0	0	0
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0
194.00	07950	CHILD CARE	138,907	7,014	130,762	175,376	16,705
194.10	07951	RETAIL PHARMACY	18,540	0	17,452	0	16,705
194.20	07952	OTHER NON-REIMBURSABLE	0	0	0	0	4,176
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,797,062	1,001,938	3,388,214	1,491,849	2,965,168

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140046

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

Worksheet B
Part I
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
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	2,505,593					13.00
14.00	01400	0	406,280				14.00
15.00	01500	173,843	4,101	6,692,574			15.00
16.00	01600	61,102	0	0	1,842,540		16.00
17.00	01700	0	0	0	0	204,716	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	746,453	33,024	91	129,272	167,867	30.00
31.00	03100	156,319	12,842	0	21,995	20,472	31.00
41.00	04100	55,617	249	0	8,020	16,377	41.00
43.00	04300	48,940	0	0	3,655	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	232,387	231,620	8,188	281,091	0	50.00
52.00	05200	40,948	0	0	26,633	0	52.00
53.00	05300	3	7,282	474	41,873	0	53.00
54.00	05400	122,779	7,887	0	139,994	0	54.00
57.00	05700	31,053	1,455	0	186,497	0	57.00
58.00	05800	12,401	1,989	0	43,738	0	58.00
59.00	05900	65,635	83,169	0	93,404	0	59.00
60.00	06000	152,222	4,502	0	276,162	0	60.00
64.00	06400	14,459	1,176	0	6,902	0	64.00
65.00	06500	91,879	4,072	3,145	56,248	0	65.00
66.00	06600	72,897	236	0	28,174	0	66.00
67.00	06700	24,358	215	0	11,474	0	67.00
68.00	06800	15,219	68	0	3,380	0	68.00
69.00	06900	48,102	836	0	63,764	0	69.00
70.01	07001	5,069	47	0	1,841	0	70.01
71.00	07100	0	0	0	13,881	0	71.00
72.00	07200	0	0	0	77,669	0	72.00
73.00	07300	0	0	5,289,192	201,600	0	73.00
76.00	03950	159	607	17,511	8,787	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	12,469	766	0	2,489	0	90.00
90.01	09001	1,803	0	0	201	0	90.01
90.04	09005	4,371	0	0	4,350	0	90.04
90.05	09003	0	0	0	99,514	0	90.05
91.00	09100	202,103	10,120	67	9,932	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		2,392,590	406,263	5,318,668	1,842,540	204,716	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	7,563	0	0	0	0	190.00
192.00	19200	77,495	1	0	0	0	192.00
192.08	19208	0	0	0	0	0	192.08
193.00	19300	0	0	0	0	0	193.00
193.05	19305	0	0	0	0	0	193.05
193.06	19306	0	0	0	0	0	193.06
194.00	07950	13,680	16	0	0	0	194.00
194.10	07951	12,934	0	1,373,906	0	0	194.10
194.20	07952	1,331	0	0	0	0	194.20
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,505,593	406,280	6,692,574	1,842,540	204,716	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140046

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

Worksheet B
Part I
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.04	00570				5.04
5.05	00580				5.05
5.06	00590				5.06
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				16.00
17.00	01700				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	26,417,563	0	26,417,563	30.00
31.00	03100	6,577,755	0	6,577,755	31.00
41.00	04100	2,497,304	0	2,497,304	41.00
43.00	04300	1,993,182	0	1,993,182	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	13,060,578	0	13,060,578	50.00
52.00	05200	2,183,261	0	2,183,261	52.00
53.00	05300	312,145	0	312,145	53.00
54.00	05400	7,325,196	0	7,325,196	54.00
57.00	05700	1,618,619	0	1,618,619	57.00
58.00	05800	655,309	0	655,309	58.00
59.00	05900	3,000,599	0	3,000,599	59.00
60.00	06000	8,844,098	0	8,844,098	60.00
64.00	06400	569,437	0	569,437	64.00
65.00	06500	2,899,564	0	2,899,564	65.00
66.00	06600	2,448,884	0	2,448,884	66.00
67.00	06700	1,012,501	0	1,012,501	67.00
68.00	06800	567,992	0	567,992	68.00
69.00	06900	3,041,935	0	3,041,935	69.00
70.01	07001	276,433	0	276,433	70.01
71.00	07100	10,409,181	0	10,409,181	71.00
72.00	07200	8,097,526	0	8,097,526	72.00
73.00	07300	12,591,212	0	12,591,212	73.00
76.00	03950	1,287,449	0	1,287,449	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	522,543	0	522,543	90.00
90.01	09001	47,199	0	47,199	90.01
90.04	09005	262,668	0	262,668	90.04
90.05	09003	103,469	0	103,469	90.05
91.00	09100	7,780,377	0	7,780,377	91.00
92.00	09200		0		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	3,948	0	3,948	99.30
99.40	09940	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00					
	SUBTOTALS (SUM OF LINES 1-117)	126,407,927	0	126,407,927	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	204,240	0	204,240	190.00
192.00	19200	13,438,169	0	13,438,169	192.00
192.08	19208	21,387	0	21,387	192.08
193.00	19300	0	0	0	193.00
193.05	19305	890	0	890	193.05
193.06	19306	0	0	0	193.06
194.00	07950	1,079,359	0	1,079,359	194.00
194.10	07951	3,384,575	0	3,384,575	194.10
194.20	07952	45,907	0	45,907	194.20
200.00		0	0	0	200.00
201.00		0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140046

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

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Part I
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
202.00	TOTAL (sum lines 118-201)	144,582,454	0	144,582,454	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140046

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2016 8: 28 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	233,144	0	233,144	4.00
5.04 00570	ADMINISTRATIVE	150	54,617	0	54,767	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	2,527	2,527	5.05
5.06 00590	ADMINISTRATIVE & GENERAL	2,819	1,188,900	1,572,320	2,764,039	5.06
6.00 00600	MAINTENANCE & REPAIRS	53,410	1,109,022	617,692	1,780,124	6.00
6.01 00601	BIOMEDICAL SERVICES	0	6,393	2,298	8,691	6.01
7.00 00700	OPERATION OF PLANT	0	361,318	29,824	391,142	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	101,811	1,368	103,179	8.00
9.00 00900	HOUSEKEEPING	31,122	237,407	41,403	309,932	9.00
10.00 01000	DIETARY	0	91,658	4,736	96,394	10.00
11.00 01100	CAFETERIA	0	239,418	11,569	250,987	11.00
13.00 01300	NURSING ADMINISTRATION	0	45,422	502,567	547,989	13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	57,233	0	0	57,233	14.00
15.00 01500	PHARMACY	178,461	80,883	28,971	288,315	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	97,070	3,782	100,852	16.00
17.00 01700	SOCIAL SERVICE	170	80,931	0	81,101	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	75,712	1,342,120	82,264	1,500,096	30.00
31.00 03100	INTENSIVE CARE UNIT	12,684	419,334	158,769	590,787	31.00
41.00 04100	SUBPROVIDER - I RF	0	216,168	0	216,168	41.00
43.00 04300	NURSERY	0	25,644	37,768	63,412	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	118,100	752,422	935,112	1,805,634	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	231,301	31,601	262,902	52.00
53.00 05300	ANESTHESIOLOGY	3,557	6,130	52,759	62,446	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	44,169	536,134	967,340	1,547,643	54.00
57.00 05700	CT SCAN	0	92,353	196,498	288,851	57.00
58.00 05800	MRI	0	51,983	15,293	67,276	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	157,672	117,792	275,464	59.00
60.00 06000	LABORATORY	3,868	212,744	241,859	458,471	60.00
64.00 06400	INTRAVENOUS THERAPY	0	32,420	2,529	34,949	64.00
65.00 06500	RESPIRATORY THERAPY	33,798	35,246	98,820	167,864	65.00
66.00 06600	PHYSICAL THERAPY	1,350	89,551	9,062	99,963	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	82,440	849	83,289	67.00
68.00 06800	SPEECH PATHOLOGY	21	16,306	1,085	17,412	68.00
69.00 06900	ELECTROCARDIOLOGY	117	419,502	155,137	574,756	69.00
70.01 07001	NEUROLOGY	26,765	31,103	15,578	73,446	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
76.00 03950	ACUTE DIALYSIS	0	25,381	7,915	33,296	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	144	51,767	6,837	58,748	90.00
90.01 09001	DIABETES EDUCATION	0	0	0	0	90.01
90.04 09005	ANTI COAGULATION CLINIC	0	24,255	0	24,255	90.04
90.05 09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	90.05
91.00 09100	EMERGENCY	120	373,146	107,188	480,454	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	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)	643,770	9,153,116	6,061,112	15,857,998	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	34,073	1,478	35,551	190.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	1,359,952	0	1,210,254	2,570,206	192.00
192.08 19208	FOUNDATION	3,702	8,644	0	12,346	192.08
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.05 19305	NON-REIMBURSABLE DEPT	0	0	0	0	193.05
193.06 19306	OUTSIDE ACCOUNTING	0	0	0	0	193.06
194.00 07950	CHILD CARE	0	238,245	1,809	240,054	194.00
194.10 07951	RETAIL PHARMACY	0	31,798	20,373	52,171	194.10
194.20 07952	OTHER NON-REIMBURSABLE	497	0	0	497	194.20
200.00	Cross Foot Adjustments				0	200.00

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,007,921	9,465,876	7,295,026	18,768,823	233,144	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140046		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 5/27/2016 8:28 pm	
Cost Center Description			ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	BIOMEDICAL SERVICES	
			5.04	5.05	5.06	6.00	6.01	
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
5.04	00570	ADMINISTRATIVE	54,767					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	2,527				5.05
5.06	00590	ADMINISTRATIVE & GENERAL	0	0	2,787,667			5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	63,474	1,845,433		6.00
6.01	00601	BIOMEDICAL SERVICES	0	0	34,021	623	43,335	6.01
7.00	00700	OPERATION OF PLANT	0	0	73,210	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	17,391	22,752	0	8.00
9.00	00900	HOUSEKEEPING	0	0	61,061	43,635	0	9.00
10.00	01000	DIETARY	0	0	24,484	65,140	0	10.00
11.00	01100	CAFETERIA	0	0	46,382	158,955	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	44,496	1,247	2,307	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	7,833	0	0	14.00
15.00	01500	PHARMACY	0	0	116,723	47,063	1,285	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	30,860	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	2,159	623	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,842	179	390,269	554,472	3,832	30.00
31.00	03100	INTENSIVE CARE UNIT	654	30	103,601	78,542	830	31.00
41.00	04100	SUBPROVIDER - I/R	238	11	37,177	30,856	0	41.00
43.00	04300	NURSERY	109	5	33,838	33,973	551	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,367	365	202,180	194,797	5,078	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	791	37	33,506	28,363	479	52.00
53.00	05300	ANESTHESIOLOGY	1,244	58	4,928	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,160	196	113,825	15,584	6,946	54.00
57.00	05700	CT SCAN	5,542	258	24,092	3,740	32	57.00
58.00	05800	MRI	1,300	60	8,639	623	1,389	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,776	129	37,605	27,427	12,159	59.00
60.00	06000	LABORATORY	8,207	382	152,987	8,415	1,110	60.00
64.00	06400	INTRAVENOUS THERAPY	205	10	8,861	19,012	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,671	78	47,672	7,792	2,682	65.00
66.00	06600	PHYSICAL THERAPY	837	39	41,441	0	327	66.00
67.00	06700	OCCUPATIONAL THERAPY	341	16	16,376	0	112	67.00
68.00	06800	SPEECH PATHOLOGY	100	5	9,869	0	56	68.00
69.00	06900	ELECTROCARDIOLOGY	1,895	88	40,636	100,983	2,635	69.00
70.01	07001	NEUROLOGY	55	3	4,093	0	375	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	412	19	200,428	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	2,308	107	154,628	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,991	279	136,900	0	0	73.00
76.00	03950	ACUTE DIALYSIS	261	12	23,136	14,337	96	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	74	3	8,400	0	0	90.00
90.01	09001	DIABETES EDUCATION	6	0	791	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	129	6	4,286	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	2,957	138	76	0	0	90.05
91.00	09100	EMERGENCY	295	14	124,306	162,383	942	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	76	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)	54,767	2,527	2,486,716	1,621,337	43,223	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	2,887	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	248,185	219,732	112	192.00
192.08	19208	FOUNDATION	0	0	213	312	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.05	19305	NON-REIMBURSABLE DEPT	0	0	17	0	0	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
194.00	07950	CHILD CARE	0	0	11,369	4,052	0	194.00
194.10	07951	RETAIL PHARMACY	0	0	37,501	0	0	194.10
194.20	07952	OTHER NON-REIMBURSABLE	0	0	779	0	0	194.20
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)	54,767	2,527	2,787,667	1,845,433	43,335	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/27/2016 8:28 pm				
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.04	00570	ADMITTING					5.04	
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05	
5.06	00590	ADMINISTRATIVE & GENERAL					5.06	
6.00	00600	MAINTENANCE & REPAIRS					6.00	
6.01	00601	BIOMEDICAL SERVICES					6.01	
7.00	00700	OPERATION OF PLANT	466,960				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	7,300	151,305			8.00	
9.00	00900	HOUSEKEEPING	17,023	757	438,647		9.00	
10.00	01000	DIETARY	6,572	308	6,513	202,261	10.00	
11.00	01100	CAFETERIA	17,167	752	17,012	0	496,346	11.00
13.00	01300	NURSING ADMINISTRATION	3,257	0	3,228	0	8,389	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	5,800	4,887	5,747	0	33,556	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,960	0	6,897	0	11,884	16.00
17.00	01700	SOCIAL SERVICE	5,803	0	5,751	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	96,233	71,051	95,367	148,790	145,411	30.00
31.00	03100	INTENSIVE CARE UNIT	30,067	14,631	29,796	8,615	30,759	31.00
41.00	04100	SUBPROVIDER - IRF	15,500	7,565	15,360	9,789	11,185	41.00
43.00	04300	NURSERY	1,839	2,270	1,822	0	9,787	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	53,950	12,604	53,464	8,152	45,440	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,585	0	16,435	0	7,690	52.00
53.00	05300	ANESTHESIOLOGY	440	0	436	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,442	13,784	38,096	0	23,769	54.00
57.00	05700	CT SCAN	6,622	0	6,561	0	6,292	57.00
58.00	05800	MRI	3,727	3,026	3,694	0	2,097	58.00
59.00	05900	CARDIAC CATHETERIZATION	11,305	1,513	11,204	0	12,583	59.00
60.00	06000	LABORATORY	15,254	0	15,117	0	29,361	60.00
64.00	06400	INTRAVENOUS THERAPY	2,325	0	2,304	0	2,796	64.00
65.00	06500	RESPIRATORY THERAPY	2,527	0	2,504	0	18,176	65.00
66.00	06600	PHYSICAL THERAPY	6,421	0	6,363	0	13,982	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,911	0	5,858	0	4,894	67.00
68.00	06800	SPEECH PATHOLOGY	1,169	0	1,159	0	2,796	68.00
69.00	06900	ELECTROCARDIOLOGY	30,079	757	29,808	0	9,088	69.00
70.01	07001	NEUROLOGY	2,230	378	2,210	0	699	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
76.00	03950	ACUTE DIALYSIS	1,820	333	1,803	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,712	0	3,678	0	2,097	90.00
90.01	09001	DIABETES EDUCATION	0	0	0	0	699	90.01
90.04	09005	ANTI COAGULATION CLINIC	1,739	0	1,723	0	699	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	26,755	15,630	26,514	3,138	39,148	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)	444,534	150,246	416,424	178,484	473,277	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	2,443	0	2,421	0	1,398	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	15,380	192.00
192.08	19208	FOUNDATION	620	0	614	0	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.05	19305	NON-REIMBURSABLE DEPT	0	0	0	0	0	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
194.00	07950	CHILD CARE	17,083	1,059	16,929	23,777	2,796	194.00
194.10	07951	RETAIL PHARMACY	2,280	0	2,259	0	2,796	194.10
194.20	07952	OTHER NON-REIMBURSABLE	0	0	0	0	699	194.20
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)	466,960	151,305	438,647	202,261	496,346	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/27/2016 8:28 pm
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.04	00570	ADMINISTRATIVE					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	BIO MEDICAL 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	615,325				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	65,066			14.00
15.00	01500	PHARMACY	42,692	657	561,759		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,005	0	0	175,632	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	95,475
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	183,312	5,289	8	12,329	78,289
31.00	03100	INTENSIVE CARE UNIT	38,389	2,057	0	2,098	9,548
41.00	04100	SUBPROVIDER - I/R	13,659	40	0	765	7,638
43.00	04300	NURSERY	12,019	0	0	349	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	57,070	37,092	687	26,718	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,056	0	0	2,540	0
53.00	05300	ANESTHESIOLOGY	1	1,166	40	3,993	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,152	1,263	0	13,351	0
57.00	05700	CT SCAN	7,626	233	0	17,786	0
58.00	05800	MRI	3,046	319	0	4,171	0
59.00	05900	CARDIAC CATHETERIZATION	16,119	13,320	0	8,908	0
60.00	06000	LABORATORY	37,383	721	0	26,337	0
64.00	06400	INTRAVENOUS THERAPY	3,551	188	0	658	0
65.00	06500	RESPIRATORY THERAPY	22,564	652	264	5,364	0
66.00	06600	PHYSICAL THERAPY	17,902	38	0	2,687	0
67.00	06700	OCCUPATIONAL THERAPY	5,982	34	0	1,094	0
68.00	06800	SPEECH PATHOLOGY	3,738	11	0	322	0
69.00	06900	ELECTROCARDIOLOGY	11,813	134	0	6,081	0
70.01	07001	NEUROLOGY	1,245	8	0	176	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	1,324	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	7,407	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	443,962	19,227	0
76.00	03950	ACUTE DIALYSIS	39	97	1,470	838	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,062	123	0	237	0
90.01	09001	DIABETES EDUCATION	443	0	0	19	0
90.04	09005	ANTI COAGULATION CLINIC	1,073	0	0	415	0
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	9,491	0
91.00	09100	EMERGENCY	49,633	1,621	6	947	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	587,574	65,063	446,437	175,632	95,475
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	1,857	0	0	0	0
192.00	19200	PHYSICIANS PRIVATE OFFICES	19,031	0	0	0	0
192.08	19208	FOUNDATION	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.05	19305	NON-REIMBURSABLE DEPT	0	0	0	0	0
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0
194.00	07950	CHILD CARE	3,360	3	0	0	0
194.10	07951	RETAIL PHARMACY	3,176	0	115,322	0	0
194.20	07952	OTHER NON-REIMBURSABLE	327	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	615,325	65,066	561,759	175,632	95,475

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/27/2016 8:28 pm
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.04	00570				5.04
5.05	00580				5.05
5.06	00590				5.06
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				16.00
17.00	01700				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	3,340,897	0	3,340,897	30.00
31.00	03100	953,484	0	953,484	31.00
41.00	04100	370,546	0	370,546	41.00
43.00	04300	164,192	0	164,192	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	2,530,455	0	2,530,455	50.00
52.00	05200	382,913	0	382,913	52.00
53.00	05300	74,752	0	74,752	53.00
54.00	05400	1,856,539	0	1,856,539	54.00
57.00	05700	369,905	0	369,905	57.00
58.00	05800	100,377	0	100,377	58.00
59.00	05900	435,404	0	435,404	59.00
60.00	06000	762,682	0	762,682	60.00
64.00	06400	76,042	0	76,042	64.00
65.00	06500	285,967	0	285,967	65.00
66.00	06600	195,721	0	195,721	66.00
67.00	06700	126,024	0	126,024	67.00
68.00	06800	38,009	0	38,009	68.00
69.00	06900	811,926	0	811,926	69.00
70.01	07001	85,282	0	85,282	70.01
71.00	07100	202,183	0	202,183	71.00
72.00	07200	164,450	0	164,450	72.00
73.00	07300	606,359	0	606,359	73.00
76.00	03950	77,650	0	77,650	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	80,989	0	80,989	90.00
90.01	09001	2,073	0	2,073	90.01
90.04	09005	34,871	0	34,871	90.04
90.05	09003	12,662	0	12,662	90.05
91.00	09100	948,234	0	948,234	91.00
92.00	09200		0		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	76	0	76	99.30
99.40	09940	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		15,090,664	0	15,090,664	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	46,816	0	46,816	190.00
192.00	19200	3,076,899	0	3,076,899	192.00
192.08	19208	14,105	0	14,105	192.08
193.00	19300	0	0	0	193.00
193.05	19305	17	0	17	193.05
193.06	19306	0	0	0	193.06
194.00	07950	321,017	0	321,017	194.00
194.10	07951	216,900	0	216,900	194.10
194.20	07952	2,405	0	2,405	194.20
200.00		0	0	0	200.00
201.00		0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140046

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2016 8:28 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
202.00	TOTAL (sum lines 118-201)	18,768,823	0	18,768,823	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

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

Worksheet B-1

Date/Time Prepared:
5/27/2016 8:28 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (ADMITTING CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	
	BLDG & FIXT (SQ FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	395,331				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		5,192,893			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	9,737	0	46,250,929		4.00
5.04 00570	ADMITTING	2,281	0	0	424,445,479	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,799	0	0	424,873,142
5.06 00590	ADMINISTRATIVE & GENERAL	49,653	1,119,243	4,687,224	0	0
6.00 00600	MAINTENANCE & REPAIRS	46,317	439,698	364,064	0	0
6.01 00601	BIO MEDICAL SERVICES	267	1,636	0	0	0
7.00 00700	OPERATION OF PLANT	15,090	21,230	517,327	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	4,252	974	135,525	0	0
9.00 00900	HOUSEKEEPING	9,915	29,472	1,237,613	0	0
10.00 01000	DIETARY	3,828	3,371	565,441	0	0
11.00 01100	CAFETERIA	9,999	8,235	1,009,829	0	0
13.00 01300	NURSING ADMINISTRATION	1,897	357,747	875,164	0	0
14.00 01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	3,378	20,623	2,982,373	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	4,054	2,692	629,728	0	0
17.00 01700	SOCIAL SERVICE	3,380	0	7,467	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	56,052	58,559	10,342,402	29,779,380	29,779,380
31.00 03100	INTENSIVE CARE UNIT	17,513	113,018	2,594,676	5,066,906	5,066,906
41.00 04100	SUBPROVIDER - IIRF	9,028	0	911,460	1,847,447	1,847,447
43.00 04300	NURSERY	1,071	26,885	836,719	841,960	841,960
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	31,424	665,650	3,740,758	64,747,066	64,747,066
52.00 05200	DELIVERY ROOM & LABOR ROOM	9,660	22,495	700,076	6,135,217	6,135,217
53.00 05300	ANESTHESIOLOGY	256	37,556	42	9,645,866	9,645,866
54.00 05400	RADIOLOGY-DIAGNOSTIC	22,391	688,591	1,850,457	32,249,242	32,676,905
57.00 05700	CT SCAN	3,857	139,875	450,349	42,961,822	42,961,822
58.00 05800	MRI	2,171	10,886	200,384	10,075,655	10,075,655
59.00 05900	CARDIAC CATHETERIZATION	6,585	83,849	970,357	21,516,634	21,516,634
60.00 06000	LABORATORY	8,885	172,165	1,772,841	63,617,095	63,617,095
64.00 06400	INTRAVENOUS THERAPY	1,354	1,800	234,684	1,590,021	1,590,021
65.00 06500	RESPIRATORY THERAPY	1,472	70,344	1,221,348	12,957,361	12,957,361
66.00 06600	PHYSICAL THERAPY	3,740	6,451	1,134,890	6,490,250	6,490,250
67.00 06700	OCCUPATIONAL THERAPY	3,443	604	420,019	2,643,107	2,643,107
68.00 06800	SPEECH PATHOLOGY	681	772	272,185	778,707	778,707
69.00 06900	ELECTROCARDIOLOGY	17,520	110,433	629,441	14,688,814	14,688,814
70.01 07001	NEUROLOGY	1,299	11,089	72,259	424,095	424,095
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	3,197,636	3,197,636
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	17,892,062	17,892,062
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	46,440,871	46,440,871
76.00 03950	ACUTE DIALYSIS	1,060	5,634	22,202	2,024,148	2,024,148
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	2,162	4,867	169,528	573,295	573,295
90.01 09001	DIABETES EDUCATION	0	0	22,750	46,350	46,350
90.04 09005	ANTI COAGULATION CLINIC	1,013	0	108,382	1,002,120	1,002,120
90.05 09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	22,924,295	22,924,295
91.00 09100	EMERGENCY	15,584	76,301	3,262,751	2,288,057	2,288,057
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	382,269	4,314,544	44,952,715	424,445,479	424,873,142
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	1,423	1,052	51,394	0	0
192.00 19200	PHYSICIANS PRIVATE OFFICES	0	861,507	843,742	0	0
192.08 19208	FOUNDATION	361	0	0	0	0
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.05 19305	NON-REIMBURSABLE DEPT	0	0	0	0	0
193.06 19306	OUTSIDE ACCOUNTING	0	0	0	0	0
194.00 07950	CHILD CARE	9,950	1,288	106,044	0	0
194.10 07951	RETAIL PHARMACY	1,328	14,502	276,667	0	0
194.20 07952	OTHER NON-REIMBURSABLE	0	0	20,367	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

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

Worksheet B-1

Date/Time Prepared:
5/27/2016 8:28 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (ADMITTING CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	
		BLDG & FIXT (SQ FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	9,465,876	7,295,026	17,458,315	54,617	2,527	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	23.944178	1.404810	0.377469	0.000129	0.000006	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			233,144	54,767	2,527	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.005041	0.000129	0.000006	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

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

Worksheet B-1

Date/Time Prepared:
5/27/2016 8:28 pm

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (TIME SPENT)	BIOMEDICAL SERVICES (TIME SPENT)	OPERATION OF PLANT (SQ FEET)	
		5A.06	5.06	6.00	6.01	7.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.04	00570						5.04
5.05	00580						5.05
5.06	00590	-31,452,463	113,129,991				5.06
6.00	00600		2,575,964	5,921			6.00
6.01	00601		1,380,683	2	5,428		6.01
7.00	00700		2,971,048	0	0	271,986	7.00
8.00	00800		705,770	73	0	4,252	8.00
9.00	00900		2,478,007	140	0	9,915	9.00
10.00	01000		993,613	209	0	3,828	10.00
11.00	01100		1,882,309	510	0	9,999	11.00
13.00	01300		1,805,786	4	289	1,897	13.00
14.00	01400		317,898	0	0	0	14.00
15.00	01500		4,736,953	151	161	3,378	15.00
16.00	01600		1,252,380	0	0	4,054	16.00
17.00	01700		87,633	2	0	3,380	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000		15,836,869	1,779	480	56,052	30.00
31.00	03100		4,204,430	252	104	17,513	31.00
41.00	04100		1,508,735	99	0	9,028	41.00
43.00	04300		1,373,227	109	69	1,071	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000		8,205,022	625	636	31,424	50.00
52.00	05200		1,359,773	91	60	9,660	52.00
53.00	05300		199,977	0	0	256	53.00
54.00	05400		4,619,341	50	870	22,391	54.00
57.00	05700		977,709	12	4	3,857	57.00
58.00	05800		350,591	2	174	2,171	58.00
59.00	05900		1,526,101	88	1,523	6,585	59.00
60.00	06000		6,208,643	27	139	8,885	60.00
64.00	06400		359,604	61	0	1,354	64.00
65.00	06500		1,934,667	25	336	1,472	65.00
66.00	06600		1,681,781	0	41	3,740	66.00
67.00	06700		664,584	0	14	3,443	67.00
68.00	06800		400,530	0	7	681	68.00
69.00	06900		1,649,117	324	330	17,520	69.00
70.01	07001		166,117	0	47	1,299	70.01
71.00	07100		8,133,904	0	0	0	71.00
72.00	07200		6,275,215	0	0	0	72.00
73.00	07300		5,555,793	0	0	0	73.00
76.00	03950		938,931	46	12	1,060	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000		340,913	0	0	2,162	90.00
90.01	09001		32,096	0	0	0	90.01
90.04	09005		173,953	0	0	1,013	90.04
90.05	09003		3,095	0	0	0	90.05
91.00	09100		5,044,681	521	118	15,584	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910		0	0	0	0	99.10
99.20	09920		0	0	0	0	99.20
99.30	09930		3,089	0	0	0	99.30
99.40	09940		0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		-31,452,463	100,916,532	5,202	5,414	258,924	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000		117,179	0	0	1,423	190.00
192.00	19200		10,072,021	705	14	0	192.00
192.08	19208		8,644	1	0	361	192.08
193.00	19300		0	0	0	0	193.00
193.05	19305		696	0	0	0	193.05
193.06	19306		0	0	0	0	193.06
194.00	07950		461,394	13	0	9,950	194.00
194.10	07951		1,521,914	0	0	1,328	194.10
194.20	07952		31,611	0	0	0	194.20
200.00							200.00
201.00							201.00
202.00			31,452,463	3,292,136	1,765,654	3,797,062	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (TIME SPENT)	BIOMEDICAL SERVICES (TIME SPENT)	OPERATION OF PLANT (SQ FEET)	
			5A.06	5.06	6.00	6.01	
203.00	Unit cost multiplier (Wkst. B, Part I)		0.278021	556.010133	325.286293	13.960505	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		2,787,667	1,845,433	43,335	466,960	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.024641	311.675899	7.983604	1.716853	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

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

Worksheet B-1

Date/Time Prepared:
5/27/2016 8:28 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQ FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTEs SERVED)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
6.00	00600						6.00
6.01	00601						6.01
7.00	00700						7.00
8.00	00800	937,815					8.00
9.00	00900	4,689	257,818				9.00
10.00	01000	1,907	3,828	176,928			10.00
11.00	01100	4,658	9,999	0	710		11.00
13.00	01300	0	1,897	0	12	1,453,692	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	30,291	3,378	0	48	100,860	15.00
16.00	01600	0	4,054	0	17	35,450	16.00
17.00	01700	0	3,380	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	440,398	56,052	130,154	208	433,076	30.00
31.00	03100	90,687	17,513	7,536	44	90,693	31.00
41.00	04100	46,891	9,028	8,563	16	32,268	41.00
43.00	04300	14,067	1,071	0	14	28,394	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	78,120	31,424	7,131	65	134,826	50.00
52.00	05200	0	9,660	0	11	23,757	52.00
53.00	05300	0	256	0	0	2	53.00
54.00	05400	85,435	22,391	0	34	71,234	54.00
57.00	05700	0	3,856	0	9	18,016	57.00
58.00	05800	18,756	2,171	0	3	7,195	58.00
59.00	05900	9,378	6,585	0	18	38,080	59.00
60.00	06000	0	8,885	0	42	88,316	60.00
64.00	06400	0	1,354	0	4	8,389	64.00
65.00	06500	0	1,472	0	26	53,306	65.00
66.00	06600	0	3,740	0	20	42,293	66.00
67.00	06700	0	3,443	0	7	14,132	67.00
68.00	06800	0	681	0	4	8,830	68.00
69.00	06900	4,689	17,520	0	13	27,908	69.00
70.01	07001	2,345	1,299	0	1	2,941	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	0	0	73.00
76.00	03950	2,063	1,060	0	0	92	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	2,162	0	3	7,234	90.00
90.01	09001	0	0	0	1	1,046	90.01
90.04	09005	0	1,013	0	1	2,536	90.04
90.05	09003	0	0	0	0	0	90.05
91.00	09100	96,876	15,584	2,745	56	117,256	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		931,250	244,756	156,129	677	1,388,130	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	1,423	0	2	4,388	190.00
192.00	19200	0	0	0	22	44,961	192.00
192.08	19208	0	361	0	0	0	192.08
193.00	19300	0	0	0	0	0	193.00
193.05	19305	0	0	0	0	0	193.05
193.06	19306	0	0	0	0	0	193.06
194.00	07950	6,565	9,950	20,799	4	7,937	194.00
194.10	07951	0	1,328	0	4	7,504	194.10
194.20	07952	0	0	0	1	772	194.20
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

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

Worksheet B-1

Date/Time Prepared:
5/27/2016 8:28 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQ FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
		8.00	9.00	10.00	11.00	13.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,001,938	3,388,214	1,491,849	2,965,168	2,505,593	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.068375	13.141883	8.431955	4,176.292958	1.723607	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	151,305	438,647	202,261	496,346	615,325	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.161338	1.701382	1.143183	699.078873	0.423284	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

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

Worksheet B-1
Date/Time Prepared:
5/27/2016 8:28 pm

Cost Center Description			CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (ADMINISTRATIVE CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.04	00570	ADMINISTRATIVE					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
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	14,553,776				14.00
15.00	01500	PHARMACY	146,919	5,086,736			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	424,445,479		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	100	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,182,971	69	29,779,380	82	30.00
31.00	03100	INTENSIVE CARE UNIT	460,034	0	5,066,906	10	31.00
41.00	04100	SUBPROVIDER - IRF	8,912	0	1,847,447	8	41.00
43.00	04300	NURSERY	0	0	841,960	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,297,148	6,223	64,747,066	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	6,135,217	0	52.00
53.00	05300	ANESTHESIOLOGY	260,864	360	9,645,866	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	282,514	0	32,249,242	0	54.00
57.00	05700	CT SCAN	52,132	0	42,961,822	0	57.00
58.00	05800	MRI	71,253	0	10,075,655	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,979,251	0	21,516,634	0	59.00
60.00	06000	LABORATORY	161,277	0	63,617,095	0	60.00
64.00	06400	INTRAVENOUS THERAPY	42,117	0	1,590,021	0	64.00
65.00	06500	RESPIRATORY THERAPY	145,867	2,390	12,957,361	0	65.00
66.00	06600	PHYSICAL THERAPY	8,439	0	6,490,250	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,712	0	2,643,107	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,443	0	778,707	0	68.00
69.00	06900	ELECTROCARDIOLOGY	29,945	0	14,688,814	0	69.00
70.01	07001	NEUROLOGY	1,694	0	424,095	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	3,197,636	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	17,892,062	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,020,087	46,440,871	0	73.00
76.00	03950	ACUTE DIALYSIS	21,759	13,309	2,024,148	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	27,437	0	573,295	0	90.00
90.01	09001	DIABETES EDUCATION	0	0	46,350	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	0	0	1,002,120	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	22,924,295	0	90.05
91.00	09100	EMERGENCY	362,502	51	2,288,057	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)	14,553,190	4,042,489	424,445,479	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	21	0	0	0	192.00
192.08	19208	FOUNDATION	0	0	0	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.05	19305	NON-REIMBURSABLE DEPT	0	0	0	0	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	193.06
194.00	07950	CHILD CARE	565	0	0	0	194.00
194.10	07951	RETAIL PHARMACY	0	1,044,247	0	0	194.10
194.20	07952	OTHER NON-REIMBURSABLE	0	0	0	0	194.20
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

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

Worksheet B-1

Date/Time Prepared:
5/27/2016 8:28 pm

Cost Center Description		CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (ADMINISTRATIVE CHARGES)	SOCIAL SERVICE (TIME SPENT)		
		14.00	15.00	16.00	17.00		
202.00	Cost to be allocated (per Wkst. B, Part I)	406,280	6,692,574	1,842,540	204,716		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.027916	1.315691	0.004341	2,047.160000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	65,066	561,759	175,632	95,475		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.004471	0.110436	0.000414	954.750000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140046

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2016 8:28 pm

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	26,417,563		26,417,563	0	26,417,563	30.00
31.00	03100 INTENSIVE CARE UNIT	6,577,755		6,577,755	11,764	6,589,519	31.00
41.00	04100 SUBPROVIDER - I RF	2,497,304		2,497,304	261	2,497,565	41.00
43.00	04300 NURSERY	1,993,182		1,993,182	0	1,993,182	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	13,060,578		13,060,578	0	13,060,578	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,183,261		2,183,261	0	2,183,261	52.00
53.00	05300 ANESTHESIOLOGY	312,145		312,145	21,896	334,041	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,325,196		7,325,196	14,710	7,339,906	54.00
57.00	05700 CT SCAN	1,618,619		1,618,619	0	1,618,619	57.00
58.00	05800 MRI	655,309		655,309	0	655,309	58.00
59.00	05900 CARDIAC CATHETERIZATION	3,000,599		3,000,599	0	3,000,599	59.00
60.00	06000 LABORATORY	8,844,098		8,844,098	40,368	8,884,466	60.00
64.00	06400 INTRAVENOUS THERAPY	569,437		569,437	0	569,437	64.00
65.00	06500 RESPIRATORY THERAPY	2,899,564	0	2,899,564	7,084	2,906,648	65.00
66.00	06600 PHYSICAL THERAPY	2,448,884	0	2,448,884	0	2,448,884	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,012,501	0	1,012,501	0	1,012,501	67.00
68.00	06800 SPEECH PATHOLOGY	567,992	0	567,992	0	567,992	68.00
69.00	06900 ELECTROCARDIOLOGY	3,041,935		3,041,935	38,607	3,080,542	69.00
70.01	07001 NEUROLOGY	276,433		276,433	5,037	281,470	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	10,409,181		10,409,181	0	10,409,181	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	8,097,526		8,097,526	0	8,097,526	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12,591,212		12,591,212	0	12,591,212	73.00
76.00	03950 ACUTE DIALYSIS	1,287,449		1,287,449	10,928	1,298,377	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	522,543		522,543	0	522,543	90.00
90.01	09001 DIABETES EDUCATION	47,199		47,199	0	47,199	90.01
90.04	09005 ANTI COAGULATION CLINIC	262,668		262,668	0	262,668	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	103,469		103,469	0	103,469	90.05
91.00	09100 EMERGENCY	7,780,377		7,780,377	0	7,780,377	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	2,536,634		2,536,634		2,536,634	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	3,948		3,948		3,948	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
200.00	Subtotal (see instructions)	128,944,561	0	128,944,561	150,655	129,095,216	200.00
201.00	Less Observation Beds	2,536,634		2,536,634		2,536,634	201.00
202.00	Total (see instructions)	126,407,927	0	126,407,927	150,655	126,558,582	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140046		Period: From 01/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 5/27/2016 8:28 pm	
			Title XVII I		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	29,779,380		29,779,380			30.00
31.00	03100	INTENSIVE CARE UNIT	5,066,906		5,066,906			31.00
41.00	04100	SUBPROVIDER - IRF	1,847,447		1,847,447			41.00
43.00	04300	NURSERY	841,960		841,960			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34,018,715	30,728,351	64,747,066	0.201717	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,785,290	2,349,927	6,135,217	0.355857	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	5,054,837	4,591,029	9,645,866	0.032360	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,805,371	23,871,534	32,676,905	0.224170	0.000000	54.00
57.00	05700	CT SCAN	12,825,147	30,136,675	42,961,822	0.037676	0.000000	57.00
58.00	05800	MRI	1,671,850	8,403,805	10,075,655	0.065039	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,750,122	11,766,512	21,516,634	0.139455	0.000000	59.00
60.00	06000	LABORATORY	33,478,892	30,138,203	63,617,095	0.139021	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	4,660	1,585,361	1,590,021	0.358132	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	11,612,007	1,345,354	12,957,361	0.223777	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,020,220	1,470,031	6,490,251	0.377317	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,300,140	342,968	2,643,108	0.383072	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	390,468	388,238	778,706	0.729405	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	6,634,618	8,054,196	14,688,814	0.207092	0.000000	69.00
70.01	07001	NEUROLOGY	262,048	162,047	424,095	0.651819	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3,197,636	3,260,298	6,457,934	1.611844	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	11,030,264	6,861,798	17,892,062	0.452576	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,416,660	13,763,914	43,180,574	0.291594	0.000000	73.00
76.00	03950	ACUTE DIALYSIS	1,902,935	121,213	2,024,148	0.636045	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,834	569,461	573,295	0.911473	0.000000	90.00
90.01	09001	DIABETES EDUCATION	315	46,035	46,350	1.018317	0.000000	90.01
90.04	09005	ANTI COAGULATION CLINIC	3,720	998,400	1,002,120	0.262112	0.000000	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0.000000	0.000000	90.05
91.00	09100	EMERGENCY	5,729,214	17,195,081	22,924,295	0.339394	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	316,993	1,971,064	2,288,057	1.108641	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)	224,751,649	200,121,495	424,873,144			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	224,751,649	200,121,495	424,873,144			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/27/2016 8:28 pm
		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
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.201717		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.355857		52.00
53.00	05300 ANESTHESIOLOGY	0.034630		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.224621		54.00
57.00	05700 CT SCAN	0.037676		57.00
58.00	05800 MRI	0.065039		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.139455		59.00
60.00	06000 LABORATORY	0.139655		60.00
64.00	06400 INTRAVENOUS THERAPY	0.358132		64.00
65.00	06500 RESPIRATORY THERAPY	0.224324		65.00
66.00	06600 PHYSICAL THERAPY	0.377317		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.383072		67.00
68.00	06800 SPEECH PATHOLOGY	0.729405		68.00
69.00	06900 ELECTROCARDIOLOGY	0.209720		69.00
70.01	07001 NEUROLOGY	0.663696		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.611844		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.452576		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.291594		73.00
76.00	03950 ACUTE DIALYSIS	0.641444		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.911473		90.00
90.01	09001 DIABETES EDUCATION	1.018317		90.01
90.04	09005 ANTI COAGULATION CLINIC	0.262112		90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0.000000		90.05
91.00	09100 EMERGENCY	0.339394		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.108641		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: 140046

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2016 8:28 pm

		Title XIX		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	26,417,563		26,417,563	0	26,417,563	30.00
31.00	03100 INTENSIVE CARE UNIT	6,577,755		6,577,755	11,764	6,589,519	31.00
41.00	04100 SUBPROVIDER - I RF	2,497,304		2,497,304	261	2,497,565	41.00
43.00	04300 NURSERY	1,993,182		1,993,182	0	1,993,182	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	13,060,578		13,060,578	0	13,060,578	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,183,261		2,183,261	0	2,183,261	52.00
53.00	05300 ANESTHESIOLOGY	312,145		312,145	21,896	334,041	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,325,196		7,325,196	14,710	7,339,906	54.00
57.00	05700 CT SCAN	1,618,619		1,618,619	0	1,618,619	57.00
58.00	05800 MRI	655,309		655,309	0	655,309	58.00
59.00	05900 CARDIAC CATHETERIZATION	3,000,599		3,000,599	0	3,000,599	59.00
60.00	06000 LABORATORY	8,844,098		8,844,098	40,368	8,884,466	60.00
64.00	06400 INTRAVENOUS THERAPY	569,437		569,437	0	569,437	64.00
65.00	06500 RESPIRATORY THERAPY	2,899,564	0	2,899,564	7,084	2,906,648	65.00
66.00	06600 PHYSICAL THERAPY	2,448,884	0	2,448,884	0	2,448,884	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,012,501	0	1,012,501	0	1,012,501	67.00
68.00	06800 SPEECH PATHOLOGY	567,992	0	567,992	0	567,992	68.00
69.00	06900 ELECTROCARDIOLOGY	3,041,935		3,041,935	38,607	3,080,542	69.00
70.01	07001 NEUROLOGY	276,433		276,433	5,037	281,470	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	10,409,181		10,409,181	0	10,409,181	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	8,097,526		8,097,526	0	8,097,526	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12,591,212		12,591,212	0	12,591,212	73.00
76.00	03950 ACUTE DIALYSIS	1,287,449		1,287,449	10,928	1,298,377	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	522,543		522,543	0	522,543	90.00
90.01	09001 DIABETES EDUCATION	47,199		47,199	0	47,199	90.01
90.04	09005 ANTI COAGULATION CLINIC	262,668		262,668	0	262,668	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	103,469		103,469	0	103,469	90.05
91.00	09100 EMERGENCY	7,780,377		7,780,377	0	7,780,377	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	2,536,634		2,536,634		2,536,634	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	3,948		3,948		3,948	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
200.00	Subtotal (see instructions)	128,944,561	0	128,944,561	150,655	129,095,216	200.00
201.00	Less Observation Beds	2,536,634		2,536,634		2,536,634	201.00
202.00	Total (see instructions)	126,407,927	0	126,407,927	150,655	126,558,582	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140046		Period: From 01/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 5/27/2016 8:28 pm	
			Title XIX		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,779,380		29,779,380			30.00
31.00	03100	INTENSIVE CARE UNIT	5,066,906		5,066,906			31.00
41.00	04100	SUBPROVIDER - IRF	1,847,447		1,847,447			41.00
43.00	04300	NURSERY	841,960		841,960			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34,018,715	30,728,351	64,747,066	0.201717	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,785,290	2,349,927	6,135,217	0.355857	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	5,054,837	4,591,029	9,645,866	0.032360	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,805,371	23,871,534	32,676,905	0.224170	0.000000	54.00
57.00	05700	CT SCAN	12,825,147	30,136,675	42,961,822	0.037676	0.000000	57.00
58.00	05800	MRI	1,671,850	8,403,805	10,075,655	0.065039	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,750,122	11,766,512	21,516,634	0.139455	0.000000	59.00
60.00	06000	LABORATORY	33,478,892	30,138,203	63,617,095	0.139021	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	4,660	1,585,361	1,590,021	0.358132	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	11,612,007	1,345,354	12,957,361	0.223777	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,020,220	1,470,031	6,490,251	0.377317	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,300,140	342,968	2,643,108	0.383072	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	390,468	388,238	778,706	0.729405	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	6,634,618	8,054,196	14,688,814	0.207092	0.000000	69.00
70.01	07001	NEUROLOGY	262,048	162,047	424,095	0.651819	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3,197,636	3,260,298	6,457,934	1.611844	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	11,030,264	6,861,798	17,892,062	0.452576	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,416,660	13,763,914	43,180,574	0.291594	0.000000	73.00
76.00	03950	ACUTE DIALYSIS	1,902,935	121,213	2,024,148	0.636045	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,834	569,461	573,295	0.911473	0.000000	90.00
90.01	09001	DIABETES EDUCATION	315	46,035	46,350	1.018317	0.000000	90.01
90.04	09005	ANTI COAGULATION CLINIC	3,720	998,400	1,002,120	0.262112	0.000000	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0.000000	0.000000	90.05
91.00	09100	EMERGENCY	5,729,214	17,195,081	22,924,295	0.339394	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	316,993	1,971,064	2,288,057	1.108641	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)	224,751,649	200,121,495	424,873,144			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	224,751,649	200,121,495	424,873,144			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/27/2016 8:28 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.201717		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.355857		52.00
53.00	05300 ANESTHESIOLOGY	0.034630		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.224621		54.00
57.00	05700 CT SCAN	0.037676		57.00
58.00	05800 MRI	0.065039		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.139455		59.00
60.00	06000 LABORATORY	0.139655		60.00
64.00	06400 INTRAVENOUS THERAPY	0.358132		64.00
65.00	06500 RESPIRATORY THERAPY	0.224324		65.00
66.00	06600 PHYSICAL THERAPY	0.377317		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.383072		67.00
68.00	06800 SPEECH PATHOLOGY	0.729405		68.00
69.00	06900 ELECTROCARDIOLOGY	0.209720		69.00
70.01	07001 NEUROLOGY	0.663696		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.611844		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.452576		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.291594		73.00
76.00	03950 ACUTE DIALYSIS	0.641444		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.911473		90.00
90.01	09001 DIABETES EDUCATION	1.018317		90.01
90.04	09005 ANTI COAGULATION CLINIC	0.262112		90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0.000000		90.05
91.00	09100 EMERGENCY	0.339394		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.108641		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: 140046

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

Worksheet C Part II Date/Time Prepared: 5/27/2016 8:28 pm

Cost Center Description			Title XIX			Hospital		PPS
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,060,578	2,530,455	10,530,123	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,183,261	382,913	1,800,348	0	0	52.00
53.00	05300	ANESTHESIOLOGY	312,145	74,752	237,393	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,325,196	1,856,539	5,468,657	0	0	54.00
57.00	05700	CT SCAN	1,618,619	369,905	1,248,714	0	0	57.00
58.00	05800	MRI	655,309	100,377	554,932	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,000,599	435,404	2,565,195	0	0	59.00
60.00	06000	LABORATORY	8,844,098	762,682	8,081,416	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	569,437	76,042	493,395	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,899,564	285,967	2,613,597	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,448,884	195,721	2,253,163	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,012,501	126,024	886,477	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	567,992	38,009	529,983	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,041,935	811,926	2,230,009	0	0	69.00
70.01	07001	NEUROLOGY	276,433	85,282	191,151	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	10,409,181	202,183	10,206,998	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	8,097,526	164,450	7,933,076	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,591,212	606,359	11,984,853	0	0	73.00
76.00	03950	ACUTE DIALYSIS	1,287,449	77,650	1,209,799	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	522,543	80,989	441,554	0	0	90.00
90.01	09001	DIABETES EDUCATION	47,199	2,073	45,126	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	262,668	34,871	227,797	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	103,469	12,662	90,807	0	0	90.05
91.00	09100	EMERGENCY	7,780,377	948,234	6,832,143	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	2,536,634	320,795	2,215,839	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	3,948	76	3,872	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)	91,458,757	10,582,340	80,876,417	0	0	200.00
201.00		Less Observation Beds	2,536,634	320,795	2,215,839	0	0	201.00
202.00		Total (line 200 minus line 201)	88,922,123	10,261,545	78,660,578	0	0	202.00

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

Provider CCN: 140046

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

Worksheet C Part II Date/Time Prepared: 5/27/2016 8:28 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	13,060,578	64,747,066	0.201717		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,183,261	6,135,217	0.355857		52.00
53.00	05300 ANESTHESIOLOGY	312,145	9,645,866	0.032360		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,325,196	32,676,905	0.224170		54.00
57.00	05700 CT SCAN	1,618,619	42,961,822	0.037676		57.00
58.00	05800 MRI	655,309	10,075,655	0.065039		58.00
59.00	05900 CARDIAC CATHETERIZATION	3,000,599	21,516,634	0.139455		59.00
60.00	06000 LABORATORY	8,844,098	63,617,095	0.139021		60.00
64.00	06400 INTRAVENOUS THERAPY	569,437	1,590,021	0.358132		64.00
65.00	06500 RESPIRATORY THERAPY	2,899,564	12,957,361	0.223777		65.00
66.00	06600 PHYSICAL THERAPY	2,448,884	6,490,251	0.377317		66.00
67.00	06700 OCCUPATIONAL THERAPY	1,012,501	2,643,108	0.383072		67.00
68.00	06800 SPEECH PATHOLOGY	567,992	778,706	0.729405		68.00
69.00	06900 ELECTROCARDIOLOGY	3,041,935	14,688,814	0.207092		69.00
70.01	07001 NEUROLOGY	276,433	424,095	0.651819		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	10,409,181	6,457,934	1.611844		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	8,097,526	17,892,062	0.452576		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12,591,212	43,180,574	0.291594		73.00
76.00	03950 ACUTE DIALYSIS	1,287,449	2,024,148	0.636045		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	522,543	573,295	0.911473		90.00
90.01	09001 DIABETES EDUCATION	47,199	46,350	1.018317		90.01
90.04	09005 ANTI COAGULATION CLINIC	262,668	1,002,120	0.262112		90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	103,469	0	0.000000		90.05
91.00	09100 EMERGENCY	7,780,377	22,924,295	0.339394		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	2,536,634	2,288,057	1.108641		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	3,948	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)	91,458,757	387,337,451			200.00
201.00	Less Observation Beds	2,536,634	0			201.00
202.00	Total (line 200 minus line 201)	88,922,123	387,337,451			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140046		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part I Date/Time Prepared: 5/27/2016 8:28 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	3,340,897	0	3,340,897	29,004	115.19	30.00
31.00	INTENSIVE CARE UNIT	953,484	0	953,484	3,062	311.39	31.00
41.00	SUBPROVIDER - IRF	370,546	0	370,546	2,588	143.18	41.00
43.00	NURSERY	164,192		164,192	1,675	98.03	43.00
200.00	Total (Lines 30-199)	4,829,119		4,829,119	36,329		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	15,395	1,773,350				
31.00	INTENSIVE CARE UNIT	1,622	505,075				
41.00	SUBPROVIDER - IRF	1,954	279,774				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	18,971	2,558,199				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 5/27/2016 8:28 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,530,455	64,747,066	0.039082	20,204,885	789,647	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	382,913	6,135,217	0.062412	6,794	424	52.00
53.00	05300 ANESTHESIOLOGY	74,752	9,645,866	0.007750	1,721,153	13,339	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,856,539	32,676,905	0.056815	5,268,808	299,347	54.00
57.00	05700 CT SCAN	369,905	42,961,822	0.008610	7,062,650	60,809	57.00
58.00	05800 MRI	100,377	10,075,655	0.009962	934,430	9,309	58.00
59.00	05900 CARDIAC CATHETERIZATION	435,404	21,516,634	0.020236	3,277,374	66,321	59.00
60.00	06000 LABORATORY	762,682	63,617,095	0.011989	18,558,409	222,497	60.00
64.00	06400 INTRAVENOUS THERAPY	76,042	1,590,021	0.047825	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	285,967	12,957,361	0.022070	6,365,400	140,484	65.00
66.00	06600 PHYSICAL THERAPY	195,721	6,490,251	0.030156	2,508,784	75,655	66.00
67.00	06700 OCCUPATIONAL THERAPY	126,024	2,643,108	0.047680	613,359	29,245	67.00
68.00	06800 SPEECH PATHOLOGY	38,009	778,706	0.048810	155,898	7,609	68.00
69.00	06900 ELECTROCARDIOLOGY	811,926	14,688,814	0.055275	4,080,297	225,538	69.00
70.01	07001 NEUROLOGY	85,282	424,095	0.201092	174,706	35,132	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	202,183	6,457,934	0.031308	1,686,664	52,806	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	164,450	17,892,062	0.009191	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	606,359	43,180,574	0.014042	15,937,009	223,787	73.00
76.00	03950 ACUTE DIALYSIS	77,650	2,024,148	0.038362	1,488,783	57,113	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	80,989	573,295	0.141269	0	0	90.00
90.01	09001 DIABETES EDUCATION	2,073	46,350	0.044725	0	0	90.01
90.04	09005 ANTI COAGULATION CLINIC	34,871	1,002,120	0.034797	0	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	12,662	0	0.000000	0	0	90.05
91.00	09100 EMERGENCY	948,234	22,924,295	0.041364	3,429,305	141,850	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	320,795	2,288,057	0.140204	190,122	26,656	92.00
200.00	Total (lines 50-199)	10,582,264	387,337,451		93,664,830	2,477,568	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140046		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part III Date/Time Prepared: 5/27/2016 8:28 pm	
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
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	29,004	0.00	15,395	0		30.00
31.00	03100	INTENSIVE CARE UNIT	3,062	0.00	1,622	0		31.00
41.00	04100	SUBPROVIDER - IRF	2,588	0.00	1,954	0		41.00
43.00	04300	NURSERY	1,675	0.00	0	0		43.00
200.00		Total (lines 30-199)	36,329		18,971	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140046

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2016 8:28 pm

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.01	07001	NEUROLOGY	0	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03950	ACUTE DIALYSIS	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	DIABETES EDUCATION	0	0	0	0	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	0	0	0	0	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140046

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2016 8:28 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	PPS
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	64,747,066	0.000000	0.000000	20,204,885	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,135,217	0.000000	0.000000	6,794	52.00
53.00	05300	ANESTHESIOLOGY	0	9,645,866	0.000000	0.000000	1,721,153	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,676,905	0.000000	0.000000	5,268,808	54.00
57.00	05700	CT SCAN	0	42,961,822	0.000000	0.000000	7,062,650	57.00
58.00	05800	MRI	0	10,075,655	0.000000	0.000000	934,430	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	21,516,634	0.000000	0.000000	3,277,374	59.00
60.00	06000	LABORATORY	0	63,617,095	0.000000	0.000000	18,558,409	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,590,021	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	12,957,361	0.000000	0.000000	6,365,400	65.00
66.00	06600	PHYSICAL THERAPY	0	6,490,251	0.000000	0.000000	2,508,784	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,643,108	0.000000	0.000000	613,359	67.00
68.00	06800	SPEECH PATHOLOGY	0	778,706	0.000000	0.000000	155,898	68.00
69.00	06900	ELECTROCARDIOLOGY	0	14,688,814	0.000000	0.000000	4,080,297	69.00
70.01	07001	NEUROLOGY	0	424,095	0.000000	0.000000	174,706	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	6,457,934	0.000000	0.000000	1,686,664	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	17,892,062	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	43,180,574	0.000000	0.000000	15,937,009	73.00
76.00	03950	ACUTE DIALYSIS	0	2,024,148	0.000000	0.000000	1,488,783	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	573,295	0.000000	0.000000	0	90.00
90.01	09001	DIABETES EDUCATION	0	46,350	0.000000	0.000000	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	0	1,002,120	0.000000	0.000000	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0.000000	0	90.05
91.00	09100	EMERGENCY	0	22,924,295	0.000000	0.000000	3,429,305	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	2,288,057	0.000000	0.000000	190,122	92.00
200.00		Total (lines 50-199)	0	387,337,451			93,664,830	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140046

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2016 8:28 pm

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		
Title XVIII Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	14,731,894	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	1,420,397	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	8,624,557	0		54.00
57.00	05700 CT SCAN	0	10,232,880	0		57.00
58.00	05800 MRI	0	2,784,078	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	3,648,538	0		59.00
60.00	06000 LABORATORY	0	6,485,663	0		60.00
64.00	06400 INTRAVENOUS THERAPY	0	93,569	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	324,327	0		65.00
66.00	06600 PHYSICAL THERAPY	0	2,041	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	240	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	3,237,703	0		69.00
70.01	07001 NEUROLOGY	0	72,382	0		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	1,849,487	0		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,525,720	0		73.00
76.00	03950 ACUTE DIALYSIS	0	112,010	0		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 DIABETES EDUCATION	0	197	0		90.01
90.04	09005 ANTI COAGULATION CLINIC	0	0	0		90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0		90.05
91.00	09100 EMERGENCY	0	5,312,183	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	758,108	0		92.00
200.00	Total (lines 50-199)	0	66,215,974	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/27/2016 8:28 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.201717	14,731,894	0	0	2,971,673 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.355857	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.032360	1,420,397	0	0	45,964 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.224170	8,624,557	225	0	1,933,367 54.00
57.00	05700 CT SCAN	0.037676	10,232,880	0	0	385,534 57.00
58.00	05800 MRI	0.065039	2,784,078	0	0	181,074 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.139455	3,648,538	0	0	508,807 59.00
60.00	06000 LABORATORY	0.139021	6,485,663	0	0	901,643 60.00
64.00	06400 INTRAVENOUS THERAPY	0.358132	93,569	0	0	33,510 64.00
65.00	06500 RESPIRATORY THERAPY	0.223777	324,327	0	0	72,577 65.00
66.00	06600 PHYSICAL THERAPY	0.377317	2,041	0	0	770 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.383072	240	0	0	92 67.00
68.00	06800 SPEECH PATHOLOGY	0.729405	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.207092	3,237,703	0	0	670,502 69.00
70.01	07001 NEUROLOGY	0.651819	72,382	0	0	47,180 70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.611844	1,849,487	0	0	2,981,085 71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.452576	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.291594	6,525,720	0	348,722	1,902,861 73.00
76.00	03950 ACUTE DIALYSIS	0.636045	112,010	0	0	71,243 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.911473	0	0	0	0 90.00
90.01	09001 DIABETES EDUCATION	1.018317	197	0	0	201 90.01
90.04	09005 ANTI COAGULATION CLINIC	0.262112	0	0	0	0 90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0.000000	0	0	0	0 90.05
91.00	09100 EMERGENCY	0.339394	5,312,183	0	0	1,802,923 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	1.108641	758,108	0	0	840,470 92.00
200.00	Subtotal (see instructions)		66,215,974	225	348,722	15,351,476 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		66,215,974	225	348,722	15,351,476 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/27/2016 8:28 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	50	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
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	101,685		73.00
76.00 03950 ACUTE DIALYSIS	0	0		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 DIABETES EDUCATION	0	0		90.01
90.04 09005 ANTI COAGULATION CLINIC	0	0		90.04
90.05 09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0		90.05
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00 Subtotal (see instructions)	50	101,685		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	50	101,685		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140046 Component CCN: 14T046		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part II Date/Time Prepared: 5/27/2016 8:28 pm	
		Title XVIII		Subprovider - IRF		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	2,530,455	64,747,066	0.039082	3,400	133	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	382,913	6,135,217	0.062412	0	0	52.00
53.00	05300 ANESTHESIOLOGY	74,752	9,645,866	0.007750	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,856,539	32,676,905	0.056815	12,775	726	54.00
57.00	05700 CT SCAN	369,905	42,961,822	0.008610	12,600	108	57.00
58.00	05800 MRI	100,377	10,075,655	0.009962	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	435,404	21,516,634	0.020236	0	0	59.00
60.00	06000 LABORATORY	762,682	63,617,095	0.011989	148,364	1,779	60.00
64.00	06400 INTRAVENOUS THERAPY	76,042	1,590,021	0.047825	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	285,967	12,957,361	0.022070	158,310	3,494	65.00
66.00	06600 PHYSICAL THERAPY	195,721	6,490,251	0.030156	1,083,865	32,685	66.00
67.00	06700 OCCUPATIONAL THERAPY	126,024	2,643,108	0.047680	1,016,340	48,459	67.00
68.00	06800 SPEECH PATHOLOGY	38,009	778,706	0.048810	107,638	5,254	68.00
69.00	06900 ELECTROCARDIOLOGY	811,926	14,688,814	0.055275	6,308	349	69.00
70.01	07001 NEUROLOGY	85,282	424,095	0.201092	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	202,183	6,457,934	0.031308	2,774	87	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	164,450	17,892,062	0.009191	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	606,359	43,180,574	0.014042	345,706	4,854	73.00
76.00	03950 ACUTE DIALYSIS	77,650	2,024,148	0.038362	19,440	746	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	80,989	573,295	0.141269	0	0	90.00
90.01	09001 DIABETES EDUCATION	2,073	46,350	0.044725	0	0	90.01
90.04	09005 ANTI COAGULATION CLINIC	34,871	1,002,120	0.034797	0	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	12,662	0	0.000000	0	0	90.05
91.00	09100 EMERGENCY	948,234	22,924,295	0.041364	184,080	7,614	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0	2,288,057	0.000000	0	0	92.00
200.00	Total (lines 50-199)	10,261,469	387,337,451		3,101,600	106,288	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140046
Component CCN: 14T046

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2016 8:28 pm

Title XVIII

Subprovider - IRF

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
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
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
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
76.00	03950	ACUTE DIALYSIS	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	DIABETES EDUCATION	0	0	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	0	0	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	90.05
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: 140046 Component CCN: 14T046	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/27/2016 8:28 pm
	Title XVIII	Subprovider - IRF	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	64,747,066	0.000000	0.000000	3,400	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	6,135,217	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	9,645,866	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	32,676,905	0.000000	0.000000	12,775	54.00
57.00	05700 CT SCAN	0	42,961,822	0.000000	0.000000	12,600	57.00
58.00	05800 MRI	0	10,075,655	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	21,516,634	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	63,617,095	0.000000	0.000000	148,364	60.00
64.00	06400 INTRAVENOUS THERAPY	0	1,590,021	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	12,957,361	0.000000	0.000000	158,310	65.00
66.00	06600 PHYSICAL THERAPY	0	6,490,251	0.000000	0.000000	1,083,865	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,643,108	0.000000	0.000000	1,016,340	67.00
68.00	06800 SPEECH PATHOLOGY	0	778,706	0.000000	0.000000	107,638	68.00
69.00	06900 ELECTROCARDIOLOGY	0	14,688,814	0.000000	0.000000	6,308	69.00
70.01	07001 NEUROLOGY	0	424,095	0.000000	0.000000	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	6,457,934	0.000000	0.000000	2,774	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	17,892,062	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	43,180,574	0.000000	0.000000	345,706	73.00
76.00	03950 ACUTE DIALYSIS	0	2,024,148	0.000000	0.000000	19,440	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	573,295	0.000000	0.000000	0	90.00
90.01	09001 DIABETES EDUCATION	0	46,350	0.000000	0.000000	0	90.01
90.04	09005 ANTI COAGULATION CLINIC	0	1,002,120	0.000000	0.000000	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0.000000	0	90.05
91.00	09100 EMERGENCY	0	22,924,295	0.000000	0.000000	184,080	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	2,288,057	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	387,337,451			3,101,600	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/27/2016 8:28 pm
	Component CCN: 14T046	Title XVIII	Subprovider - IRF 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
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
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	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
76.00 03950 ACUTE DIALYSIS	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
90.01 09001 DIABETES EDUCATION	0	0	0	90.01
90.04 09005 ANTI COAGULATION CLINIC	0	0	0	90.04
90.05 09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	90.05
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 ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140046		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part I Date/Time Prepared: 5/27/2016 8:28 pm		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	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	3,340,897	0	3,340,897	29,004	115.19	30.00	
31.00	INTENSIVE CARE UNIT	953,484	0	953,484	3,062	311.39	31.00	
41.00	SUBPROVIDER - IRF	370,546	0	370,546	2,588	143.18	41.00	
43.00	NURSERY	164,192		164,192	1,675	98.03	43.00	
200.00	Total (lines 30-199)	4,829,119		4,829,119	36,329		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	4,059	467,556					30.00
31.00	INTENSIVE CARE UNIT	492	153,204					31.00
41.00	SUBPROVIDER - IRF	195	27,920					41.00
43.00	NURSERY	1,254	122,930					43.00
200.00	Total (lines 30-199)	6,000	771,610					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 5/27/2016 8:28 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,530,455	64,747,066	0.039082	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	382,913	6,135,217	0.062412	0	0	52.00
53.00	05300 ANESTHESIOLOGY	74,752	9,645,866	0.007750	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,856,539	32,676,905	0.056815	0	0	54.00
57.00	05700 CT SCAN	369,905	42,961,822	0.008610	0	0	57.00
58.00	05800 MRI	100,377	10,075,655	0.009962	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	435,404	21,516,634	0.020236	0	0	59.00
60.00	06000 LABORATORY	762,682	63,617,095	0.011989	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	76,042	1,590,021	0.047825	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	285,967	12,957,361	0.022070	0	0	65.00
66.00	06600 PHYSICAL THERAPY	195,721	6,490,251	0.030156	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	126,024	2,643,108	0.047680	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	38,009	778,706	0.048810	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	811,926	14,688,814	0.055275	0	0	69.00
70.01	07001 NEUROLOGY	85,282	424,095	0.201092	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	202,183	6,457,934	0.031308	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	164,450	17,892,062	0.009191	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	606,359	43,180,574	0.014042	0	0	73.00
76.00	03950 ACUTE DIALYSIS	77,650	2,024,148	0.038362	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	80,989	573,295	0.141269	0	0	90.00
90.01	09001 DIABETES EDUCATION	2,073	46,350	0.044725	0	0	90.01
90.04	09005 ANTI COAGULATION CLINIC	34,871	1,002,120	0.034797	0	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	12,662	0	0.000000	0	0	90.05
91.00	09100 EMERGENCY	948,234	22,924,295	0.041364	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	320,795	2,288,057	0.140204	0	0	92.00
200.00	Total (lines 50-199)	10,582,264	387,337,451		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140046		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part III Date/Time Prepared: 5/27/2016 8:28 pm	
Cost Center Description			Title XIX		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	29,004	0.00	4,059	0		30.00
31.00	03100	INTENSIVE CARE UNIT	3,062	0.00	492	0		31.00
41.00	04100	SUBPROVIDER - IRF	2,588	0.00	195	0		41.00
43.00	04300	NURSERY	1,675	0.00	1,254	0		43.00
200.00		Total (lines 30-199)	36,329		6,000	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/27/2016 8:28 pm
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Cost Center Description	Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	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
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03950	ACUTE DIALYSIS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES EDUCATION	0	0	0	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	0	0	0	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05
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: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/27/2016 8:28 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	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	64,747,066	0.000000	0.000000	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	6,135,217	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	9,645,866	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	32,676,905	0.000000	0.000000	0	54.00
57.00	05700 CT SCAN	0	42,961,822	0.000000	0.000000	0	57.00
58.00	05800 MRI	0	10,075,655	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	21,516,634	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	63,617,095	0.000000	0.000000	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	1,590,021	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	12,957,361	0.000000	0.000000	0	65.00
66.00	06600 PHYSICAL THERAPY	0	6,490,251	0.000000	0.000000	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,643,108	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	778,706	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	14,688,814	0.000000	0.000000	0	69.00
70.01	07001 NEUROLOGY	0	424,095	0.000000	0.000000	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	6,457,934	0.000000	0.000000	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	17,892,062	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	43,180,574	0.000000	0.000000	0	73.00
76.00	03950 ACUTE DIALYSIS	0	2,024,148	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	573,295	0.000000	0.000000	0	90.00
90.01	09001 DIABETES EDUCATION	0	46,350	0.000000	0.000000	0	90.01
90.04	09005 ANTI COAGULATION CLINIC	0	1,002,120	0.000000	0.000000	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0.000000	0	90.05
91.00	09100 EMERGENCY	0	22,924,295	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	2,288,057	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	387,337,451			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140046

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2016 8:28 pm

Cost Center Description		Title XIX			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		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
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
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	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
76.00	03950 ACUTE DIALYSIS	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 DIABETES EDUCATION	0	0	0		90.01
90.04	09005 ANTI COAGULATION CLINIC	0	0	0		90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0		90.05
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: 140046 Component CCN: 14T046		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part II Date/Time Prepared: 5/27/2016 8:28 pm	
		Title XIX		Subprovider - IRF		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	2,530,455	64,747,066	0.039082	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	382,913	6,135,217	0.062412	0	0 52.00
53.00	05300	ANESTHESIOLOGY	74,752	9,645,866	0.007750	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,856,539	32,676,905	0.056815	0	0 54.00
57.00	05700	CT SCAN	369,905	42,961,822	0.008610	0	0 57.00
58.00	05800	MRI	100,377	10,075,655	0.009962	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	435,404	21,516,634	0.020236	0	0 59.00
60.00	06000	LABORATORY	762,682	63,617,095	0.011989	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	76,042	1,590,021	0.047825	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	285,967	12,957,361	0.022070	0	0 65.00
66.00	06600	PHYSICAL THERAPY	195,721	6,490,251	0.030156	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	126,024	2,643,108	0.047680	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	38,009	778,706	0.048810	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	811,926	14,688,814	0.055275	0	0 69.00
70.01	07001	NEUROLOGY	85,282	424,095	0.201092	0	0 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	202,183	6,457,934	0.031308	0	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	164,450	17,892,062	0.009191	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	606,359	43,180,574	0.014042	0	0 73.00
76.00	03950	ACUTE DIALYSIS	77,650	2,024,148	0.038362	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	80,989	573,295	0.141269	0	0 90.00
90.01	09001	DIABETES EDUCATION	2,073	46,350	0.044725	0	0 90.01
90.04	09005	ANTI COAGULATION CLINIC	34,871	1,002,120	0.034797	0	0 90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	12,662	0	0.000000	0	0 90.05
91.00	09100	EMERGENCY	948,234	22,924,295	0.041364	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	2,288,057	0.000000	0	0 92.00
200.00		Total (lines 50-199)	10,261,469	387,337,451		0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/27/2016 8:28 pm
Title XIX		Subprovider - IRF	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
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
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
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
76.00	03950	ACUTE DIALYSIS	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	DIABETES EDUCATION	0	0	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	0	0	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	90.05
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: 140046 Component CCN: 14T046	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/27/2016 8:28 pm
	Title XIX	Subprovider - IRF	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	64,747,066	0.000000	0.000000		0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	6,135,217	0.000000	0.000000		0 52.00
53.00	05300 ANESTHESIOLOGY	0	9,645,866	0.000000	0.000000		0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	32,676,905	0.000000	0.000000		0 54.00
57.00	05700 CT SCAN	0	42,961,822	0.000000	0.000000		0 57.00
58.00	05800 MRI	0	10,075,655	0.000000	0.000000		0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0	21,516,634	0.000000	0.000000		0 59.00
60.00	06000 LABORATORY	0	63,617,095	0.000000	0.000000		0 60.00
64.00	06400 INTRAVENOUS THERAPY	0	1,590,021	0.000000	0.000000		0 64.00
65.00	06500 RESPIRATORY THERAPY	0	12,957,361	0.000000	0.000000		0 65.00
66.00	06600 PHYSICAL THERAPY	0	6,490,251	0.000000	0.000000		0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,643,108	0.000000	0.000000		0 67.00
68.00	06800 SPEECH PATHOLOGY	0	778,706	0.000000	0.000000		0 68.00
69.00	06900 ELECTROCARDIOLOGY	0	14,688,814	0.000000	0.000000		0 69.00
70.01	07001 NEUROLOGY	0	424,095	0.000000	0.000000		0 70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	6,457,934	0.000000	0.000000		0 71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	17,892,062	0.000000	0.000000		0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	43,180,574	0.000000	0.000000		0 73.00
76.00	03950 ACUTE DIALYSIS	0	2,024,148	0.000000	0.000000		0 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	573,295	0.000000	0.000000		0 90.00
90.01	09001 DIABETES EDUCATION	0	46,350	0.000000	0.000000		0 90.01
90.04	09005 ANTI COAGULATION CLINIC	0	1,002,120	0.000000	0.000000		0 90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0.000000		0 90.05
91.00	09100 EMERGENCY	0	22,924,295	0.000000	0.000000		0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	2,288,057	0.000000	0.000000		0 92.00
200.00	Total (lines 50-199)	0	387,337,451				0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/27/2016 8:28 pm
Title XIX		Subprovider - IRF	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
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
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	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
76.00 03950 ACUTE DIALYSIS	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
90.01 09001 DIABETES EDUCATION	0	0	0	90.01
90.04 09005 ANTI COAGULATION CLINIC	0	0	0	90.04
90.05 09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	90.05
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: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/27/2016 8:28 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		29,004	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		29,004	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)		26,219	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)		15,395	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)		26,417,563	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)		26,417,563	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)		26,417,563	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)		910.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		14,022,074	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		14,022,074	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/27/2016 8:28 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	6,589,519	3,062	2,152.03	1,622	3,490,593	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)					22,087,137	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					39,599,804	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)					2,278,425	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,477,568	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					4,755,993	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					34,843,811	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)					2,785	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					910.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,536,634	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/27/2016 8:28 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,340,897	26,417,563	0.126465	2,536,634	320,795	90.00
91.00	Nursing School cost	0	26,417,563	0.000000	2,536,634	0	91.00
92.00	Allied health cost	0	26,417,563	0.000000	2,536,634	0	92.00
93.00	All other Medical Education	0	26,417,563	0.000000	2,536,634	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/27/2016 8:28 pm
		Title XVIII	Subprovider - IRF	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)		2,588	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,588	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)		2,588	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)		1,954	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)		2,497,565	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)		2,497,565	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)		2,497,565	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)		965.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,885,727	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)		1,885,727	41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
					Component CCN: 14T046		Date/Time Prepared: 5/27/2016 8:28 pm
					Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	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)					1,118,614	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,004,341	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)					279,774	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					106,288	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					386,062	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,618,279	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: 140046 Component CCN: 14T046		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/27/2016 8:28 pm	
		Title XVIII		Subprovider - IRF		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	370,546	2,497,565	0.148363	0	0	90.00
91.00	Nursing School cost	0	2,497,565	0.000000	0	0	91.00
92.00	Allied health cost	0	2,497,565	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,497,565	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/27/2016 8:28 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		29,004	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		29,004	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)		26,219	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)		4,059	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)		1,675	15.00
16.00	Nursery days (title V or XIX only)		1,254	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)		26,417,563	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)		26,417,563	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)		26,417,563	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)		910.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,697,018	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)		3,697,018	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/27/2016 8:28 pm	
Cost Center Description			Title XIX		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	1.00	2.00	3.00	4.00	5.00	42.00
NURSERY (title V & XIX only)						
Intensive Care Type Inpatient Hospital Units						
43.00	1,993,182	1,675	1,189.96	1,254	1,492,210	43.00
44.00						44.00
45.00						45.00
46.00						46.00
47.00						47.00
Intensive Care Unit						
43.00	6,589,519	3,062	2,152.03	492	1,058,799	43.00
44.00						44.00
45.00						45.00
46.00						46.00
47.00						47.00
Other Special Care (Specify)						
Cost Center Description						
					1.00	
48.00					0	48.00
Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0
49.00					6,248,027	49.00
Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						6,248,027
PASS THROUGH COST ADJUSTMENTS						
50.00					743,690	50.00
Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						743,690
51.00					0	51.00
Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0
52.00					743,690	52.00
Total Program excludable cost (sum of lines 50 and 51)						743,690
53.00					5,504,337	53.00
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						5,504,337
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00					0	54.00
Program discharges						0
55.00					0.00	55.00
Target amount per discharge						0.00
56.00					0	56.00
Target amount (line 54 x line 55)						0
57.00					0	57.00
Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0
58.00					0	58.00
Bonus payment (see instructions)						0
59.00					0.00	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
60.00					0.00	60.00
Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00
61.00					0	61.00
If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0
62.00					0	62.00
Relief payment (see instructions)						0
63.00					0	63.00
Allowable Inpatient cost plus incentive payment (see instructions)						0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00					0	64.00
Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0
65.00					0	65.00
Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0
66.00					0	66.00
Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0
67.00					0	67.00
Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0
68.00					0	68.00
Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0
69.00					0	69.00
Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00						70.00
Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						
71.00						71.00
Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						
72.00						72.00
Program routine service cost (line 9 x line 71)						
73.00						73.00
Medically necessary private room cost applicable to Program (line 14 x line 35)						
74.00						74.00
Total Program general inpatient routine service costs (line 72 + line 73)						
75.00						75.00
Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						
76.00						76.00
Per diem capital-related costs (line 75 ÷ line 2)						
77.00						77.00
Program capital-related costs (line 9 x line 76)						
78.00						78.00
Inpatient routine service cost (line 74 minus line 77)						
79.00						79.00
Aggregate charges to beneficiaries for excess costs (from provider records)						
80.00						80.00
Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						
81.00						81.00
Inpatient routine service cost per diem limitation						
82.00						82.00
Inpatient routine service cost limitation (line 9 x line 81)						
83.00						83.00
Reasonable inpatient routine service costs (see instructions)						
84.00						84.00
Program inpatient ancillary services (see instructions)						
85.00						85.00
Utilization review - physician compensation (see instructions)						
86.00						86.00
Total Program inpatient operating costs (sum of lines 83 through 85)						
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00					2,785	87.00
Total observation bed days (see instructions)						2,785
88.00					910.82	88.00
Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						910.82
89.00					2,536,634	89.00
Observation bed cost (line 87 x line 88) (see instructions)						2,536,634

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/27/2016 8:28 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,340,897	26,417,563	0.126465	2,536,634	320,795	90.00
91.00	Nursing School cost	0	26,417,563	0.000000	2,536,634	0	91.00
92.00	Allied health cost	0	26,417,563	0.000000	2,536,634	0	92.00
93.00	All other Medical Education	0	26,417,563	0.000000	2,536,634	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/27/2016 8:28 pm
		Title XIX	Subprovider - IRF	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)		2,588	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,588	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)		2,588	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)		195	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)		1,675	15.00
16.00	Nursery days (title V or XIX only)		1,254	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)		2,497,565	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)		2,497,565	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)		2,497,565	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)		965.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		188,187	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)		188,187	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
		Component CCN: 14T046		Date/Time Prepared: 5/27/2016 8:28 pm			
		Title XIX		Subprovider - IRF		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	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	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	0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					188,187		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)					27,920		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)					27,920		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					160,267		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: 140046 Component CCN: 14T046		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/27/2016 8:28 pm	
		Title XIX		Subprovider - IRF		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	370,546	2,497,565	0.148363	0	0	90.00
91.00	Nursing School cost	0	2,497,565	0.000000	0	0	91.00
92.00	Allied health cost	0	2,497,565	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,497,565	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/27/2016 8:28 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		12,233,927	30.00
31.00	03100	INTENSIVE CARE UNIT		2,407,502	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.201717	20,204,885	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.355857	6,794	52.00
53.00	05300	ANESTHESIOLOGY	0.034630	1,721,153	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.224621	5,268,808	54.00
57.00	05700	CT SCAN	0.037676	7,062,650	57.00
58.00	05800	MRI	0.065039	934,430	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.139455	3,277,374	59.00
60.00	06000	LABORATORY	0.139655	18,558,409	60.00
64.00	06400	INTRAVENOUS THERAPY	0.358132	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.224324	6,365,400	65.00
66.00	06600	PHYSICAL THERAPY	0.377317	2,508,784	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.383072	613,359	67.00
68.00	06800	SPEECH PATHOLOGY	0.729405	155,898	68.00
69.00	06900	ELECTROCARDIOLOGY	0.209720	4,080,297	69.00
70.01	07001	NEUROLOGY	0.663696	174,706	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.611844	1,686,664	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.452576	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.291594	15,937,009	73.00
76.00	03950	ACUTE DIALYSIS	0.641444	1,488,783	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.911473	0	90.00
90.01	09001	DIABETES EDUCATION	1.018317	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	0.262112	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0.000000	0	90.05
91.00	09100	EMERGENCY	0.339394	3,429,305	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	1.108641	190,122	92.00
200.00		Total (sum of lines 50-94 and 96-98)		93,664,830	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)		93,664,830	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/27/2016 8:28 pm
		Title XVIII	Subprovider - IRF	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
41.00	04100 SUBPROVIDER - IRF		1,378,992	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.201717	3,400	686 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.355857	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.034630	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.224621	12,775	2,870 54.00
57.00	05700 CT SCAN	0.037676	12,600	475 57.00
58.00	05800 MRI	0.065039	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.139455	0	0 59.00
60.00	06000 LABORATORY	0.139655	148,364	20,720 60.00
64.00	06400 INTRAVENOUS THERAPY	0.358132	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0.224324	158,310	35,513 65.00
66.00	06600 PHYSICAL THERAPY	0.377317	1,083,865	408,961 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.383072	1,016,340	389,331 67.00
68.00	06800 SPEECH PATHOLOGY	0.729405	107,638	78,512 68.00
69.00	06900 ELECTROCARDIOLOGY	0.209720	6,308	1,323 69.00
70.01	07001 NEUROLOGY	0.663696	0	0 70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.611844	2,774	4,471 71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.452576	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.291594	345,706	100,806 73.00
76.00	03950 ACUTE DIALYSIS	0.641444	19,440	12,470 76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.911473	0	0 90.00
90.01	09001 DIABETES EDUCATION	1.018317	0	0 90.01
90.04	09005 ANTI COAGULATION CLINIC	0.262112	0	0 90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0.000000	0	0 90.05
91.00	09100 EMERGENCY	0.339394	184,080	62,476 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	1.108641	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		3,101,600	1,118,614 200.00
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)		3,101,600	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/27/2016 8:28 pm
		Title XVIII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		22,092,677	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		7,246,621	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)		1,281,115	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)		107.52	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)		6.47	30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.69	31.00
32.00	Sum of lines 30 and 31		29.16	32.00
33.00	Allowable disproportionate share percentage (see instructions)		13.27	33.00
34.00	Disproportionate share adjustment (see instructions)		973,332	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/27/2016 8:28 pm	
		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)		0.000143513	0.000143352	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,097,533	918,331	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		820,894	230,837	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,051,731		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)		32,645,476		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		32,645,476		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,614,797		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		1,036		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)		35,261,309		59.00
60.00	Primary payer payments		21,250		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		35,240,059		61.00
62.00	Deductibles billed to program beneficiaries		3,030,230		62.00
63.00	Coinurance billed to program beneficiaries		53,865		63.00
64.00	Allowable bad debts (see instructions)		874,576		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		568,474		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		720,343		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		32,724,438		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-14,309		70.93
70.94	HRR adjustment amount (see instructions)		-176,731		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/27/2016 8:28 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		32,533,398		71.00
71.01	Sequestration adjustment (see instructions)		650,668		71.01
72.00	Interim payments		31,516,546		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)		366,184		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)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140046

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/27/2016 8:28 pm

		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	22,092,677	0	22,092,677	0	22,092,677	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,246,621	0	0	7,246,621	7,246,621	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	1,281,115	0	1,061,681	219,434	1,281,115	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	0.1327	0.1327	0.1327	0.1327		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	973,332	0	732,925	240,407	973,332	11.00
11.01	Uncompensated care payments	36.00	1,051,731	0	820,894	230,837	1,051,731	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	32,645,476	0	24,708,177	7,937,299	32,645,476	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	32,645,476	0	24,708,177	7,937,299	32,645,476	15.00
16.00	Payment for inpatient program capital	50.00	2,614,797	0	1,981,543	633,254	2,614,797	16.00
17.00	Special add-on payments for new technologies	54.00	1,036	0	0	1,036	1,036	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: 140046

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/27/2016 8:28 pm

		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	26,689,720	8,571,589	35,261,309	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	2,332,549	0	1,755,659	576,890	2,332,549	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	282,248	0	282,248	56,364	338,612	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	2,614,797	0	1,981,543	633,254	2,614,797	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 140046		Period: From 01/01/2015 To 12/31/2015		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/27/2016 8:28 pm	
		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	22,092,677	22,092,677		22,092,677	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,246,621		7,246,621	7,246,621	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	1,281,115	1,061,681	219,434	1,281,115	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	0.1327	0.1327	0.1327		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	973,332	732,925	240,407	973,332	11.00
11.01	Uncompensated care payments	36.00	1,051,731	820,894	230,837	1,051,731	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	32,645,476	24,708,177	7,937,299	32,645,476	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	32,645,476	24,708,177	7,937,299	32,645,476	15.00
16.00	Payment for inpatient program capital	50.00	2,614,797	2,037,907	576,890	2,614,797	16.00
17.00	Special add-on payments for new technologies	54.00	1,036	0	1,036	1,036	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			26,746,084	8,515,225	35,261,309	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/27/2016 8:28 pm
		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	2,332,549	1,755,659	576,890	2,332,549	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	282,248	282,248	0	282,248	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	2,614,797	2,037,907	576,890	2,614,797	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	-14,309	19,945	-34,254	-14,309	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-176,731	-130,346	-46,385	-176,731	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/27/2016 8:28 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			101,735 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			15,351,476 2.00
3.00	PPS payments			11,603,543 3.00
4.00	Outlier payment (see instructions)			224,658 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)			101,735 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			348,947 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)			348,947 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)			348,947 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			247,212 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)			101,735 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)			11,828,201 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			45 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,323,863 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)			9,606,028 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)			9,606,028 30.00
31.00	Primary payer payments			59 31.00
32.00	Subtotal (line 30 minus line 31)			9,605,969 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)			479,446 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			311,640 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			389,658 36.00
37.00	Subtotal (see instructions)			9,917,609 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)			13,100 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			9,917,609 40.00
40.01	Sequestration adjustment (see instructions)			198,352 40.01
41.00	Interim payments			9,502,694 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			216,563 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: 140046

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

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2016 8:28 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		31,173,213		9,396,342	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		161,055		104,042	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	08/12/2015	182,278	08/12/2015	2,310	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)		182,278		2,310	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)		31,516,546		9,502,694	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		366,184		216,563	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		31,882,730		9,719,257	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: 140046
Component CCN: 14T046

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

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2016 8:28 pm

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					0 1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3,578,379			0 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					0 3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	08/12/2015	8,807			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)		8,807			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)		3,587,186			0 4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					0 5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0			0 5.01
5.02			0			0 5.02
5.03			0			0 5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0			0 5.50
5.51			0			0 5.51
5.52			0			0 5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0			0 5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					0 6.00
6.01	SETTLEMENT TO PROVIDER		3,651			0 6.01
6.02	SETTLEMENT TO PROGRAM		0			0 6.02
7.00	Total Medicare program liability (see instructions)		3,590,837			0 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					0 8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 140046

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

Worksheet E-1
Part II
Date/Time Prepared:
5/27/2016 8:28 pm

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			7,365 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			17,017 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1,255 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			29,281 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			424,873,144 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			5,615,644 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)			1,025,500 8.00
9.00	Sequestration adjustment amount (see instructions)			20,510 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,004,990 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			967,191 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)			37,799 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part III Date/Time Prepared: 5/27/2016 8:28 pm
		Title VIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			3,138,387 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0287 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			103,253 3.00
4.00	Outlier Payments			438,859 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	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 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	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 7.00
8.00	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 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			7.090411 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			3,680,499 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			3,680,499 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			3,680,499 19.00
20.00	Deductibles			16,380 20.00
21.00	Subtotal (line 19 minus line 20)			3,664,119 21.00
22.00	Coinsurance			0 22.00
23.00	Subtotal (line 21 minus line 22)			3,664,119 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			3,664,119 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			3,664,119 32.00
32.01	Sequestration adjustment (see instructions)			73,282 32.01
33.00	Interim payments			3,587,186 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)			3,651 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			438,859 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: 140046

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

Worksheet G

Date/Time Prepared:
5/27/2016 8:28 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-2,831,050	0	0	0	1.00
2.00	Temporary investments	233,402	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	43,804,989	0	0	0	4.00
5.00	Other receivable	2,026,595	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-21,158,607	0	0	0	6.00
7.00	Inventory	3,645,115	0	0	0	7.00
8.00	Prepaid expenses	2,349,164	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)	28,069,608	0	0	0	11.00
FIXED ASSETS						
12.00	Land	632,759	0	0	0	12.00
13.00	Land improvements	6,613,257	0	0	0	13.00
14.00	Accumulated depreciation	-2,708,866	0	0	0	14.00
15.00	Buildings	156,387,350	0	0	0	15.00
16.00	Accumulated depreciation	-19,124,638	0	0	0	16.00
17.00	Leasehold improvements	17,273,279	0	0	0	17.00
18.00	Accumulated depreciation	-2,633,991	0	0	0	18.00
19.00	Fixed equipment	14,487,858	0	0	0	19.00
20.00	Accumulated depreciation	-3,136,442	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	57,270,796	0	0	0	23.00
24.00	Accumulated depreciation	-28,976,040	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)	196,085,322	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	7,085,163	513,241	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,085,163	513,241	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	231,240,093	513,241	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	5,597,250	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)	5,805,900	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,683,818	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	17,086,968	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	131,215,991	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	12,093,619	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	143,309,610	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	160,396,578	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	70,843,515				52.00
53.00	Specific purpose fund		513,241			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)	70,843,515	513,241	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	231,240,093	513,241	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140046

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

Worksheet G-1

Date/Time Prepared:
5/27/2016 8:28 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		72,810,024		718,099	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		6,974,510			2.00
3.00	Total (sum of line 1 and line 2)		79,784,534		718,099	3.00
4.00	ADDITIONS	0		697,597		4.00
5.00	GAIN ON INVESTMENTS	0		0		5.00
6.00	DONATIONS	0		0		6.00
7.00	TRANSFERS FROM OTHER FUNDS	15,277		0		7.00
8.00	CORPORATE OFFICE	554,842		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		570,119		697,597	10.00
11.00	Subtotal (line 3 plus line 10)		80,354,653		1,415,696	11.00
12.00	DEDUCTIONS (DEBIT)	8,552,817		902,455		12.00
13.00	CORPORATE OFFICE	98,743		0		13.00
14.00	TRANSFER TO OTHER RELATED ORGANIZATI	859,578		0		14.00
15.00	TRANSFER TO OTHER FUNDS	0		0		15.00
16.00	LOSS ON INVESTMENTS	0		0		16.00
17.00	TRANSFER DEBT TO CORP.	0		0		17.00
18.00	Total deductions (sum of lines 12-17)		9,511,138		902,455	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		70,843,515		513,241	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		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 (DEBIT)		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: 140046

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/27/2016 8:28 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	29,109,314		29,109,314	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	1,891,157		1,891,157	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)	31,000,471		31,000,471	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,151,925		5,151,925	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,151,925		5,151,925	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	36,152,396		36,152,396	17.00
18.00	Ancillary services	185,940,575	195,193,041	381,133,616	18.00
19.00	Outpatient services	6,180,520	21,499,779	27,680,299	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 REIMBURSABLE/PRO FEES)	9,127,822	3,273,673	12,401,495	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	237,401,313	219,966,493	457,367,806	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		160,634,676		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)		160,634,676		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140046

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

Worksheet G-3

Date/Time Prepared:
5/27/2016 8:28 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	457,367,806	1.00
2.00	Less contractual allowances and discounts on patients' accounts	298,167,759	2.00
3.00	Net patient revenues (line 1 minus line 2)	159,200,047	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	160,634,676	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,434,629	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	135,885	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	4,774	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	11,593	21.00
22.00	Rental of hospital space	174,952	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER - DONATIONS	0	24.00
24.01	OTHER - EHR	0	24.01
24.02	OTHER-MANAGEMENT FEES	85,238	24.02
24.03	OTHER-SUPPORT SERVICES	97,361	24.03
24.04	OTHER-INTEREST INCOME	45,096	24.04
24.05	OTHER-CHILD CARE	327,684	24.05
24.06	OTHER	7,627,007	24.06
25.00	Total other income (sum of lines 6-24)	8,509,590	25.00
26.00	Total (line 5 plus line 25)	7,074,961	26.00
27.00	OTHER EXPENSES	100,451	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	100,451	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,974,510	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140046	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/27/2016 8:28 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,332,549	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		282,248	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)		82.55	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)		2,614,797	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