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: 140077	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/27/2016 12:55 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/27/2016 Time: 12:55 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by TOUCHETTE REGIONAL HOSPITAL (140077) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	279,863	45,729	129,615	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	279,863	45,729	129,615	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2016 10:36 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 5900 BOND STREET	PO Box:			1.00
2.00	City: CENTREVILLE	State: IL	Zip Code: 62207	County: ST. CLAIR	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	TOUCHETTE REGIONAL HOSPITAL	140077	41180	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	SOUTHERN ILLINOIS HOME CARE	147315	41180		01/01/1996	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2015	12/31/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,502	1,889	68	2	2,653	90	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2016 10:36 am

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2016 10:36 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2016 10:36 am

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

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

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	707,539	0	0	118.01

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

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		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		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: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Number:	141.00
142.00	Street: 2041 GOOSE LAKE ROAD	PO Box:		142.00
143.00	City: SAUGET	State:	Zip Code: 62206	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

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

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.25	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)	10/01/2014	09/30/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140077	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/27/2016 10:36 am

		1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)	N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2016 10:36 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	04/22/2016 4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
				Y/N	Legal Oper.
				1.00	2.00
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N	7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N	8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N	9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N	10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N	11.00
					Y/N
					1.00
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y 12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N 13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N 14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				Y 15.00
				Part A	Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	05/03/2016	Y 16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N 18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N 19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N 20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2016 10:36 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
			Y/N	Date		
			1.00	2.00		
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
			1.00	2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN			41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM			43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2016 10:36 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	05/03/2016			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		DIRECTOR, 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: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/27/2016 10:36 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	111	40,515	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)		111	40,515	0.00	0	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	43.00				0	13.00
14.00	Total (see instructions)		111	40,515	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		111				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: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2016 10:36 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,030	1,249	8,899			1.00
2.00	HMO and other (see instructions)	0	4,612				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)	2,030	1,249	8,899			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		253	585			13.00
14.00	Total (see instructions)	2,030	1,502	9,484	0.00	454.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,047	0	14,139	0.00	19.26	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	473.26	27.00
28.00	Observation Bed Days		0	880			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	90	91			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: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2016 10:36 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	444	412	2,434	1.00
2.00	HMO and other (see instructions)			0	752		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	444	412	2,434	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/27/2016 10:36 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	26,248,489	0	26,248,489	984,390.01	26.66	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		165,754	0	165,754	832.00	199.22	4.01
5.00	Physician-Part B		1,190,503	0	1,190,503	8,904.63	133.69	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)		3,068,739	36,775	3,105,514	111,646.89	27.82	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		685,561	0	685,561	12,118.02	56.57	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		36,000	0	36,000	288.00	125.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	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)		5,897,274	0	5,897,274			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		753,235	0	753,235			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		18,216	0	18,216			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		141,562	0	141,562			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	278,223	0	278,223	10,876.76	25.58	26.00
27.00	Administrative & General	5.00	4,070,769	0	4,070,769	148,122.37	27.48	27.00
28.00	Administrative & General under contract (see inst.)		214,282	0	214,282	2,539.01	84.40	28.00
29.00	Maintenance & Repairs	6.00	531,697	0	531,697	24,268.50	21.91	29.00
30.00	Operation of Plant	7.00	1,118,479	0	1,118,479	65,788.12	17.00	30.00
31.00	Laundry & Linen Service	8.00	22,219	0	22,219	2,092.42	10.62	31.00
32.00	Housekeeping	9.00	552,283	0	552,283	48,396.21	11.41	32.00
33.00	Housekeeping under contract (see instructions)		55,000	0	55,000	2,184.00	25.18	33.00
34.00	Dietary	10.00	420,037	-321,931	98,106	7,994.31	12.27	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	321,931	321,931	26,232.92	12.27	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,303,065	-883,536	419,529	16,327.26	25.70	38.00
39.00	Central Services and Supply	14.00	101,176	66,648	167,824	6,788.06	24.72	39.00
40.00	Pharmacy	15.00	740,463	-740,463	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/27/2016 10:36 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	573,694	0	573,694	35,287.24	16.26	41.00
42.00	Social Service	17.00	232,898	0	232,898	10,491.60	22.20	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part III Date/Time Prepared: 5/27/2016 10:36 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		25,161,514	0	25,161,514	979,376.39	25.69	1.00
2.00	Excluded area salaries (see instructions)		3,068,739	36,775	3,105,514	111,646.89	27.82	2.00
3.00	Subtotal salaries (line 1 minus line 2)		22,092,775	-36,775	22,056,000	867,729.50	25.42	3.00
4.00	Subtotal other wages & related costs (see inst.)		721,561	0	721,561	12,406.02	58.16	4.00
5.00	Subtotal wage-related costs (see inst.)		5,915,490	0	5,915,490	0.00	26.82	5.00
6.00	Total (sum of lines 3 thru 5)		28,729,826	-36,775	28,693,051	880,135.52	32.60	6.00
7.00	Total overhead cost (see instructions)		10,214,285	-1,557,351	8,656,934	407,388.78	21.25	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 5/27/2016 10:36 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	667,954	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	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)	3,605,230	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	59,261	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	5,886	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	83,531	14.00
15.00	'Workers' Compensation Insurance	324,706	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,871,817	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	25,858	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	166,044	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,810,287	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part V | Date/Time Prepared: 5/27/2016 10:36 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,038,458	0	1.00
2.00	Hospital	935,843	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	102,615	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 140077 | Component CCN: 147315 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-4 | Date/Time Prepared: 5/27/2016 10:36 am

Home Health Agency I | PPS

		1.00	
0.00	County	ST. CLAIR	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	185.00	128.00	883.00	1,196.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		1.02	0.00	1.02	4.00
5.00	Other Administrative Personnel		7.39	0.00	7.39	5.00
6.00	Direct Nursing Service		6.51	0.00	6.51	6.00
7.00	Nursing Supervisor		2.00	0.00	2.00	7.00
8.00	Physical Therapy Service		2.25	0.00	2.25	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.09	0.00	0.09	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		41180			20.00

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	933	0	75	0	1,008	21.00
22.00	Skilled Nursing Visit Charges	134,352	0	10,800	0	145,152	22.00
23.00	Physical Therapy Visits	816	0	6	0	822	23.00
24.00	Physical Therapy Visit Charges	117,504	0	864	0	118,368	24.00
25.00	Occupational Therapy Visits	194	0	0	0	194	25.00
26.00	Occupational Therapy Visit Charges	27,936	0	0	0	27,936	26.00
27.00	Speech Pathology Visits	8	0	0	0	8	27.00
28.00	Speech Pathology Visit Charges	1,152	0	0	0	1,152	28.00
29.00	Medical Social Service Visits	14	0	1	0	15	29.00
30.00	Medical Social Service Visit Charges	2,688	0	192	0	2,880	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,965	0	82	0	2,047	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	283,632	0	11,856	0	295,488	35.00
36.00	Total Number of Episodes (standard/non outlier)	118		37	0	155	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	528	0	0	0	528	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140077	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 5/27/2016 10:36 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.723814	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	13,499,033	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	27,783,760	5.00
6.00	Medicaid charges	40,272,250	6.00
7.00	Medicaid cost (line 1 times line 6)	29,149,618	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)	0	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)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,553,302	0	1,553,302	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,124,302	0	1,124,302	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,124,302	0	1,124,302	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,100,353	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	301,011	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,799,342	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,026,203	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,150,505	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,150,505	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/27/2016 10:36 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		870,414	870,414	124,066	994,480	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,383,710	1,383,710	79,134	1,462,844	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	278,223	5,064,994	5,343,217	-75,039	5,268,178	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,070,769	7,275,940	11,346,709	-136,372	11,210,337	5.00
6.00	00600	MAINTENANCE & REPAIRS	531,697	231,960	763,657	0	763,657	6.00
7.00	00700	OPERATION OF PLANT	1,118,479	715,903	1,834,382	0	1,834,382	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,219	101,988	124,207	0	124,207	8.00
9.00	00900	HOUSEKEEPING	552,283	337,645	889,928	0	889,928	9.00
10.00	01000	DIETARY	420,037	659,349	1,079,386	-827,279	252,107	10.00
11.00	01100	CAFETERIA	0	0	0	827,279	827,279	11.00
13.00	01300	NURSING ADMINISTRATION	1,303,065	107,177	1,410,242	-883,536	526,706	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	101,176	23,811	124,987	66,648	191,635	14.00
15.00	01500	PHARMACY	740,463	115,116	855,579	-740,463	115,116	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	573,694	192,613	766,307	0	766,307	16.00
17.00	01700	SOCIAL SERVICE	232,898	22,882	255,780	0	255,780	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,055,466	1,537,727	5,593,193	1,007,833	6,601,026	30.00
43.00	04300	NURSERY	622,809	76,448	699,257	16,113	715,370	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	765,513	379,431	1,144,944	119,750	1,264,694	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	914,388	149,340	1,063,728	-602,196	461,532	52.00
53.00	05300	ANESTHESIOLOGY	0	951,834	951,834	0	951,834	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,323,858	669,039	1,992,897	0	1,992,897	54.00
60.00	06000	LABORATORY	631,550	2,023,873	2,655,423	0	2,655,423	60.00
65.00	06500	RESPIRATORY THERAPY	741,211	539,847	1,281,058	0	1,281,058	65.00
66.00	06600	PHYSICAL THERAPY	0	395,212	395,212	0	395,212	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	203,811	203,811	0	203,811	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	339,277	339,277	0	339,277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	561,560	561,560	740,463	1,302,023	73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	69,943	9,061	79,004	0	79,004	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	479,145	160,003	639,148	15,738	654,886	90.01
91.00	09100	EMERGENCY	3,630,864	1,408,331	5,039,195	271,722	5,310,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,308,530	354,386	1,662,916	36,775	1,699,691	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		66,828	66,828	-66,828	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,488,280	26,929,510	51,417,790	-26,192	51,391,598	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	63,545	45,890	109,435	0	109,435	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,221,651	3,103,129	4,324,780	26,192	4,350,972	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	240,844	82,404	323,248	0	323,248	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	234,169	-98,700	135,469	0	135,469	194.01
200.00		TOTAL (SUM OF LINES 118-199)	26,248,489	30,062,233	56,310,722	0	56,310,722	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/27/2016 10:36 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,054	993,426		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-168	1,462,676		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-7,959	5,260,219		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,952,932	8,257,405		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	763,657		6.00
7.00	00700	OPERATION OF PLANT	0	1,834,382		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	124,207		8.00
9.00	00900	HOUSEKEEPING	0	889,928		9.00
10.00	01000	DIETARY	0	252,107		10.00
11.00	01100	CAFETERIA	-244,631	582,648		11.00
13.00	01300	NURSING ADMINISTRATION	-1,686	525,020		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	191,635		14.00
15.00	01500	PHARMACY	0	115,116		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-47,978	718,329		16.00
17.00	01700	SOCIAL SERVICE	-400	255,380		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-907,456	5,693,570		30.00
43.00	04300	NURSERY	0	715,370		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-37,440	1,227,254		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	461,532		52.00
53.00	05300	ANESTHESIOLOGY	-927,641	24,193		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,992,897		54.00
60.00	06000	LABORATORY	0	2,655,423		60.00
65.00	06500	RESPIRATORY THERAPY	-270,880	1,010,178		65.00
66.00	06600	PHYSICAL THERAPY	-850	394,362		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	203,811		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	339,277		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,302,023		73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	-507	78,497		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PARTIAL HOSPITALIZATION	-104,712	550,174		90.01
91.00	09100	EMERGENCY	-2,174,942	3,135,975		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-3,965	1,695,726		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,685,201	43,706,397		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	109,435		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,350,972		192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	323,248		194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	135,469		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-7,685,201	48,625,521		200.00

RECLASSIFICATIONS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/27/2016 10:36 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	321,931	505,348		1.00
	0		321,931	505,348		
	B - ER & HOSPITALIST PHYSICIAN BENEFITS					
1.00	EMERGENCY	91.00	0	37,971		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	10,876		2.00
	0		0	48,847		
	C - CLINIC PHYSICIAN BENEFITS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	26,192		1.00
	0		0	26,192		
	D - INTEREST EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,172		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	21,912		2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	38,744		3.00
	0		0	66,828		
	E - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	158,284		1.00
	0		0	158,284		
	F - LABOR & DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	621,168	101,451		1.00
	0		621,168	101,451		
	G - PHARMACY SALARIES					
1.00	DRUGS CHARGED TO PATIENTS	73.00	740,463	0		1.00
	TOTALS		740,463	0		
	H - NURSE MGR SALARIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	66,648	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	274,338	0		2.00
3.00	NURSERY	43.00	16,113	0		3.00
4.00	OPERATING ROOM	50.00	119,750	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	120,423	0		5.00
6.00	PARTIAL HOSPITALIZATION	90.01	15,738	0		6.00
7.00	EMERGENCY	91.00	233,751	0		7.00
8.00	HOME HEALTH AGENCY	101.00	36,775	0		8.00
	TOTALS		883,536	0		
500.00	Grand Total: Increases		2,567,098	906,950		500.00

RECLASSIFICATIONS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/27/2016 10:36 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA COSTS						
1.00	DIETARY	10.00	321,931	505,348	0		1.00
	0		321,931	505,348			
	B - ER & HOSPITALIST PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	48,847	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	48,847			
	C - CLINIC PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	26,192	0		1.00
	0		0	26,192			
	D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	66,828	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	11		3.00
	0		0	66,828			
	E - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	158,284	0		1.00
	0		0	158,284			
	F - LABOR & DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	621,168	101,451	0		1.00
	0		621,168	101,451			
	G - PHARMACY SALARIES						
1.00	PHARMACY	15.00	740,463	0	0		1.00
	TOTALS		740,463	0			
	H - NURSE MGR SALARIES						
1.00	NURSING ADMINISTRATION	13.00	883,536	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		883,536	0			
500.00	Grand Total: Decreases		2,567,098	906,950			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/27/2016 10:36 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,192,647	0	0	0	0	1.00
2.00	Land Improvements	674,674	0	0	0	0	2.00
3.00	Buildings and Fixtures	21,122,868	23,289	0	23,289	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	368,425	11,143	0	11,143	0	5.00
6.00	Movable Equipment	20,595,704	263,721	0	263,721	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	44,954,318	298,153	0	298,153	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	44,954,318	298,153	0	298,153	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,192,647	0	1.00
2.00	Land Improvements	674,674	0	2.00
3.00	Buildings and Fixtures	21,146,157	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	379,568	0	5.00
6.00	Movable Equipment	20,859,425	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	45,252,471	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	45,252,471	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/27/2016 10:36 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	870,414	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,383,710	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,254,124	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	870,414		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,383,710		2.00
3.00	Total (sum of lines 1-2)	0	2,254,124		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/27/2016 10:36 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	24,393,046	0	24,393,046	0.539043	85,322	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	20,859,425	0	20,859,425	0.460957	72,962	2.00
3.00	Total (sum of lines 1-2)	45,252,471	0	45,252,471	1.000000	158,284	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	85,322	870,414	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	72,962	1,383,710	0	2.00
3.00	Total (sum of lines 1-2)	0	0	158,284	2,254,124	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	37,690	85,322	0	0	993,426	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,004	72,962	0	0	1,462,676	2.00
3.00	Total (sum of lines 1-2)	43,694	158,284	0	0	2,456,102	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/27/2016 10:36 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,054	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-168	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-596	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-273	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-25,290	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-24,583	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,425,671			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-87,946			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-244,631	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-1,686	NURSING ADMINISTRATION	13.00	0	17.00
18.00	Sale of medical records and abstracts	B	-47,978	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MARKETING COSTS - BENEFITS	A	-7,959	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	NON-ALLOWABLE ADVERTISING	A	-16,360	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/27/2016 10:36 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	NON-ALLOWABLE ADVERTISING	A	-507	OTHER ANCILLARY - NUTRITIONAL	76.00	0	33.02
34.00	PROVIDER TAX	A	-2,530,188	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	NON-ALLOWABLE ADVERTISING	A	-2,096	HOME HEALTH AGENCY	101.00	0	35.00
36.00	TRANSPORTATION	B	-3,186	ADMINISTRATIVE & GENERAL	5.00	0	36.00
36.01	NON-ALLOWABLE ADVERTISING	A	-400	SOCIAL SERVICE	17.00	0	36.01
37.00	MISC INCOME	B	-198,700	ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.01	POST PT FIT	B	-850	PHYSICAL THERAPY	66.00	0	37.01
38.00	LOBBYING EXPENSES	A	-14,266	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	MARKETING COSTS	A	-50,813	ADMINISTRATIVE & GENERAL	5.00	0	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,685,201				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: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 5/27/2016 10:36 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	SIHF SERVICES	0	87,946	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	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			0	87,946	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B	SIHF	100.00	SIHF	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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.

(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: 140077	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-1 Date/Time Prepared: 5/27/2016 10:36 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-87,946	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-87,946			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	NOT FOR PROFIT		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: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/27/2016 10:36 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	731	731	0	179,000	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	917,497	899,497	18,000	197,500	144	2.00
3.00	30.00	ADULTS & PEDIATRICS	12,000	0	12,000	181,300	96	3.00
4.00	50.00	OPERATING ROOM	37,440	37,440	0	246,400	0	4.00
5.00	53.00	ANESTHESIOLOGY	927,641	927,641	0	239,400	0	5.00
6.00	60.00	LABORATORY	0	0	0	260,300	0	6.00
7.00	65.00	RESPIRATORY THERAPY	275,761	269,761	6,000	211,500	48	7.00
8.00	91.00	EMERGENCY	2,259,542	2,093,788	165,754	211,500	832	8.00
9.00	90.01	PARTIAL HOSPITALIZATION	104,712	104,712	0	181,300	0	9.00
10.00	101.00	HOME HEALTH AGENCY	6,000	0	6,000	179,000	48	10.00
200.00			4,541,324	4,333,570	207,754		1,168	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	13,673	684	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	8,368	418	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	4,881	244	0	0	0	7.00
8.00	91.00	EMERGENCY	84,600	4,230	0	0	0	8.00
9.00	90.01	PARTIAL HOSPITALIZATION	0	0	0	0	0	9.00
10.00	101.00	HOME HEALTH AGENCY	4,131	207	0	0	0	10.00
200.00			115,653	5,783	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	731		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	13,673	4,327	903,824		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	8,368	3,632	3,632		3.00
4.00	50.00	OPERATING ROOM	0	0	0	37,440		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	927,641		5.00
6.00	60.00	LABORATORY	0	0	0	0		6.00
7.00	65.00	RESPIRATORY THERAPY	0	4,881	1,119	270,880		7.00
8.00	91.00	EMERGENCY	0	84,600	81,154	2,174,942		8.00
9.00	90.01	PARTIAL HOSPITALIZATION	0	0	0	104,712		9.00
10.00	101.00	HOME HEALTH AGENCY	0	4,131	1,869	1,869		10.00
200.00			0	115,653	92,101	4,425,671		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/27/2016 10:36 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	993,426	993,426				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,462,676		1,462,676			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,260,219	11,787	17,355	5,289,361		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,257,405	56,092	82,588	892,030	9,288,115	5.00
6.00	00600	MAINTENANCE & REPAIRS	763,657	47,747	70,301	117,757	999,462	6.00
7.00	00700	OPERATION OF PLANT	1,834,382	147,608	217,331	247,714	2,447,035	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	124,207	7,612	11,207	4,921	147,947	8.00
9.00	00900	HOUSEKEEPING	889,928	14,782	21,764	122,316	1,048,790	9.00
10.00	01000	DIETARY	252,107	40,054	58,974	21,728	372,863	10.00
11.00	01100	CAFETERIA	582,648	15,278	22,494	71,299	691,719	11.00
13.00	01300	NURSING ADMINISTRATION	525,020	24,152	35,560	92,915	677,647	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	191,635	12,534	18,455	37,169	259,793	14.00
15.00	01500	PHARMACY	115,116	10,491	15,446	0	141,053	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	718,329	18,258	26,883	127,058	890,528	16.00
17.00	01700	SOCIAL SERVICE	255,380	3,015	4,439	51,581	314,415	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,693,570	268,676	395,585	1,072,892	7,430,723	30.00
43.00	04300	NURSERY	715,370	9,825	14,466	141,505	881,166	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,227,254	89,900	132,364	196,063	1,645,581	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	461,532	5,873	8,648	91,611	567,664	52.00
53.00	05300	ANESTHESIOLOGY	24,193	0	0	0	24,193	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,992,897	26,549	39,089	293,200	2,351,735	54.00
60.00	06000	LABORATORY	2,655,423	25,951	38,210	139,872	2,859,456	60.00
65.00	06500	RESPIRATORY THERAPY	1,010,178	20,390	30,022	164,159	1,224,749	65.00
66.00	06600	PHYSICAL THERAPY	394,362	23,079	33,981	0	451,422	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	203,811	0	0	0	203,811	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	339,277	0	0	0	339,277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,302,023	0	0	163,993	1,466,016	73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	78,497	0	0	15,491	93,988	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	550,174	34,649	51,016	109,604	745,443	90.01
91.00	09100	EMERGENCY	3,135,975	74,670	109,940	579,160	3,899,745	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,695,726	0	0	297,950	1,993,676	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	43,706,397	988,972	1,456,118	5,051,988	43,458,012	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	109,435	1,786	2,629	14,074	127,924	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,350,972	0	0	118,096	4,469,068	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	323,248	0	0	53,341	376,589	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	135,469	2,668	3,929	51,862	193,928	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	48,625,521	993,426	1,462,676	5,289,361	48,625,521	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/27/2016 10:36 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,288,115					5.00
6.00	00600	MAINTENANCE & REPAIRS	235,987	1,235,449				6.00
7.00	00700	OPERATION OF PLANT	577,779	207,749	3,232,563			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,932	10,713	33,697	227,289		8.00
9.00	00900	HOUSEKEEPING	247,634	20,805	65,439	0	1,382,668	9.00
10.00	01000	DIETARY	88,038	56,374	177,321	0	18,393	10.00
11.00	01100	CAFETERIA	163,325	21,502	67,634	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	160,002	33,993	106,921	0	4,579	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	61,341	17,641	55,490	0	11,486	14.00
15.00	01500	PHARMACY	33,305	14,765	46,442	0	13,776	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	210,266	25,698	80,830	0	11,486	16.00
17.00	01700	SOCIAL SERVICE	74,238	4,243	13,346	0	52,814	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,754,498	378,143	1,189,423	129,984	656,818	30.00
43.00	04300	NURSERY	208,056	13,828	43,496	0	34,459	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	388,545	126,528	397,987	6,819	137,798	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	134,033	8,266	26,001	10,933	18,431	52.00
53.00	05300	ANESTHESIOLOGY	5,712	0	0	0	11,486	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	555,278	37,366	117,532	22,729	36,749	54.00
60.00	06000	LABORATORY	675,158	36,525	114,887	0	45,945	60.00
65.00	06500	RESPIRATORY THERAPY	289,180	28,698	90,269	11,365	22,973	65.00
66.00	06600	PHYSICAL THERAPY	106,587	32,483	102,172	11,365	68,918	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,123	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,108	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	346,147	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	22,192	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	176,010	48,767	153,393	0	0	90.01
91.00	09100	EMERGENCY	920,784	105,093	330,564	34,094	174,546	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	470,735	0	0	0	55,142	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,067,993	1,229,180	3,212,844	227,289	1,375,799	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,205	2,513	7,906	0	4,579	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,055,210	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	88,918	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	45,789	3,756	11,813	0	2,290	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,288,115	1,235,449	3,232,563	227,289	1,382,668	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/27/2016 10:36 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	712,989					10.00
11.00	01100	CAFETERIA	0	944,180				11.00
13.00	01300	NURSING ADMINISTRATION	0	25,376	1,008,518			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,542	20,086	436,379		14.00
15.00	01500	PHARMACY	0	31,484	0	99	280,924	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	54,847	0	69	0	16.00
17.00	01700	SOCIAL SERVICE	0	16,284	0	4	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	712,989	279,908	389,798	55,547	4,988	30.00
43.00	04300	NURSERY	0	27,895	53,103	6,106	141	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	45,023	85,733	56,767	3,253	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	16,748	31,896	16,168	1,153	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	8,367	110	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	73,946	0	8,369	17,935	54.00
60.00	06000	LABORATORY	0	48,837	0	1,697	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	42,405	0	34,349	59	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,250	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	72,617	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	120,885	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	241,692	73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	0	0	0	53	6	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	0	27,248	51,866	98	0	90.01
91.00	09100	EMERGENCY	0	133,803	254,836	46,728	6,817	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	121,200	4,351	94	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	712,989	834,346	1,008,518	433,524	276,248	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,727	0	4	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	53,552	0	2,851	4,676	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	22,786	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	26,769	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	712,989	944,180	1,008,518	436,379	280,924	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/27/2016 10:36 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,273,724					16.00
17.00	01700	SOCIAL SERVICE	0	475,344				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,151,069	213,655	14,347,543	0	14,347,543	30.00
43.00	04300	NURSERY	27,253	29,107	1,324,610	0	1,324,610	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	46,991	2,941,025	0	2,941,025	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,482	848,775	0	848,775	52.00
53.00	05300	ANESTHESIOLOGY	0	0	49,868	0	49,868	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,221,639	0	3,221,639	54.00
60.00	06000	LABORATORY	0	0	3,782,505	0	3,782,505	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,744,047	0	1,744,047	65.00
66.00	06600	PHYSICAL THERAPY	0	0	774,197	0	774,197	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	324,551	0	324,551	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	540,270	0	540,270	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,053,855	0	2,053,855	73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	0	0	116,239	0	116,239	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	0	28,429	1,231,254	0	1,231,254	90.01
91.00	09100	EMERGENCY	95,402	139,680	6,142,092	0	6,142,092	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	2,645,198	0	2,645,198	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,273,724	475,344	42,087,668	0	42,087,668	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	179,858	0	179,858	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	5,585,357	0	5,585,357	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	488,293	0	488,293	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	0	284,345	0	284,345	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,273,724	475,344	48,625,521	0	48,625,521	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/27/2016 10:36 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,126	11,787	17,355	37,268	37,268	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	160,566	56,092	82,588	299,246	6,283	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	47,747	70,301	118,048	829	6.00
7.00	00700	OPERATION OF PLANT	0	147,608	217,331	364,939	1,745	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,612	11,207	18,819	35	8.00
9.00	00900	HOUSEKEEPING	0	14,782	21,764	36,546	862	9.00
10.00	01000	DIETARY	0	40,054	58,974	99,028	153	10.00
11.00	01100	CAFETERIA	0	15,278	22,494	37,772	502	11.00
13.00	01300	NURSING ADMINISTRATION	49	24,152	35,560	59,761	654	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	233	12,534	18,455	31,222	262	14.00
15.00	01500	PHARMACY	44,932	10,491	15,446	70,869	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,258	26,883	45,141	895	16.00
17.00	01700	SOCIAL SERVICE	0	3,015	4,439	7,454	363	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,922	268,676	395,585	666,183	7,570	30.00
43.00	04300	NURSERY	0	9,825	14,466	24,291	997	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	89,900	132,364	222,264	1,381	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,873	8,648	14,521	645	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	179,821	26,549	39,089	245,459	2,065	54.00
60.00	06000	LABORATORY	98	25,951	38,210	64,259	985	60.00
65.00	06500	RESPIRATORY THERAPY	3,205	20,390	30,022	53,617	1,156	65.00
66.00	06600	PHYSICAL THERAPY	0	23,079	33,981	57,060	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,155	73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	0	0	0	0	109	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	0	34,649	51,016	85,665	772	90.01
91.00	09100	EMERGENCY	0	74,670	109,940	184,610	4,079	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	43,926	0	0	43,926	2,099	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	442,878	988,972	1,456,118	2,887,968	35,596	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,786	2,629	4,415	99	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	165,235	0	0	165,235	832	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	14,535	0	0	14,535	376	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	2,668	3,929	6,597	365	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	622,648	993,426	1,462,676	3,078,750	37,268	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/27/2016 10:36 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	305,529					5.00
6.00	00600	MAINTENANCE & REPAIRS	7,763	126,640				6.00
7.00	00700	OPERATION OF PLANT	19,006	21,295	406,985			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,149	1,098	4,242	25,343		8.00
9.00	00900	HOUSEKEEPING	8,146	2,133	8,239	0	55,926	9.00
10.00	01000	DIETARY	2,896	5,779	22,325	0	744	10.00
11.00	01100	CAFETERIA	5,373	2,204	8,515	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,263	3,484	13,462	0	185	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,018	1,808	6,986	0	465	14.00
15.00	01500	PHARMACY	1,096	1,513	5,847	0	557	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,917	2,634	10,177	0	465	16.00
17.00	01700	SOCIAL SERVICE	2,442	435	1,680	0	2,136	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,709	38,762	149,751	14,495	26,567	30.00
43.00	04300	NURSERY	6,844	1,417	5,476	0	1,394	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,781	12,970	50,107	760	5,574	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,409	847	3,274	1,219	745	52.00
53.00	05300	ANESTHESIOLOGY	188	0	0	0	465	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,266	3,830	14,798	2,534	1,486	54.00
60.00	06000	LABORATORY	22,209	3,744	14,464	0	1,858	60.00
65.00	06500	RESPIRATORY THERAPY	9,513	2,942	11,365	1,267	929	65.00
66.00	06600	PHYSICAL THERAPY	3,506	3,330	12,864	1,267	2,788	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,583	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,635	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,387	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	730	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	5,790	4,999	19,312	0	0	90.01
91.00	09100	EMERGENCY	30,289	10,773	41,619	3,801	7,060	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	15,485	0	0	0	2,230	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	265,393	125,997	404,503	25,343	55,648	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	994	258	995	0	185	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	34,711	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	2,925	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	1,506	385	1,487	0	93	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	305,529	126,640	406,985	25,343	55,926	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/27/2016 10:36 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	130,925					10.00
11.00	01100	CAFETERIA	0	54,366				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,461	84,270			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	607	1,678	45,046		14.00
15.00	01500	PHARMACY	0	1,813	0	10	81,705	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,158	0	7	0	16.00
17.00	01700	SOCIAL SERVICE	0	938	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	130,925	16,118	32,571	5,734	1,451	30.00
43.00	04300	NURSERY	0	1,606	4,437	630	41	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,592	7,164	5,860	946	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	964	2,665	1,669	335	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	864	32	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,258	0	864	5,216	54.00
60.00	06000	LABORATORY	0	2,812	0	175	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,442	0	3,546	17	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	129	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,496	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,480	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	70,295	73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	0	0	0	5	2	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	0	1,569	4,334	10	0	90.01
91.00	09100	EMERGENCY	0	7,704	21,294	4,824	1,983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	10,127	449	27	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	130,925	48,042	84,270	44,752	80,345	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	387	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,084	0	294	1,360	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	1,312	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	1,541	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	130,925	54,366	84,270	45,046	81,705	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/27/2016 10:36 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	69,394					16.00
17.00	01700	SOCIAL SERVICE	0	15,448				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,711	6,944	1,217,491	0	1,217,491	30.00
43.00	04300	NURSERY	1,485	946	49,564	0	49,564	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,527	323,926	0	323,926	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	568	31,861	0	31,861	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,549	0	1,549	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	298,776	0	298,776	54.00
60.00	06000	LABORATORY	0	0	110,506	0	110,506	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	86,794	0	86,794	65.00
66.00	06600	PHYSICAL THERAPY	0	0	80,944	0	80,944	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	9,079	0	9,079	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	15,115	0	15,115	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	82,837	0	82,837	73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	0	0	846	0	846	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	0	924	123,375	0	123,375	90.01
91.00	09100	EMERGENCY	5,198	4,539	327,773	0	327,773	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	74,343	0	74,343	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,394	15,448	2,834,779	0	2,834,779	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	7,333	0	7,333	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	205,516	0	205,516	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	19,148	0	19,148	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	0	11,974	0	11,974	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	69,394	15,448	3,078,750	0	3,078,750	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/27/2016 10:36 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	146,307					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		146,307				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,736	1,736	23,882,512			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,261	8,261	4,027,697	-9,288,115	39,337,406	5.00
6.00	00600	MAINTENANCE & REPAIRS	7,032	7,032	531,697	0	999,462	6.00
7.00	00700	OPERATION OF PLANT	21,739	21,739	1,118,479	0	2,447,035	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,121	1,121	22,219	0	147,947	8.00
9.00	00900	HOUSEKEEPING	2,177	2,177	552,283	0	1,048,790	9.00
10.00	01000	DIETARY	5,899	5,899	98,106	0	372,863	10.00
11.00	01100	CAFETERIA	2,250	2,250	321,931	0	691,719	11.00
13.00	01300	NURSING ADMINISTRATION	3,557	3,557	419,529	0	677,647	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,846	1,846	167,824	0	259,793	14.00
15.00	01500	PHARMACY	1,545	1,545	0	0	141,053	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,689	2,689	573,694	0	890,528	16.00
17.00	01700	SOCIAL SERVICE	444	444	232,898	0	314,415	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,569	39,569	4,844,303	0	7,430,723	30.00
43.00	04300	NURSERY	1,447	1,447	638,922	0	881,166	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,240	13,240	885,263	0	1,645,581	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	865	865	413,643	0	567,664	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	24,193	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,910	3,910	1,323,858	0	2,351,735	54.00
60.00	06000	LABORATORY	3,822	3,822	631,550	0	2,859,456	60.00
65.00	06500	RESPIRATORY THERAPY	3,003	3,003	741,211	0	1,224,749	65.00
66.00	06600	PHYSICAL THERAPY	3,399	3,399	0	0	451,422	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	203,811	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	339,277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	740,463	0	1,466,016	73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	0	0	69,943	0	93,988	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	5,103	5,103	494,883	0	745,443	90.01
91.00	09100	EMERGENCY	10,997	10,997	2,615,027	0	3,899,745	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	1,345,305	0	1,993,676	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	145,651	145,651	22,810,728	-9,288,115	34,169,897	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	263	263	63,545	0	127,924	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	533,226	0	4,469,068	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	240,844	0	376,589	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	393	393	234,169	0	193,928	194.01
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)	993,426	1,462,676	5,289,361		9,288,115	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.790010	9.997307	0.221474		0.236114	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			37,268		305,529	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001560		0.007767	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/27/2016 10:36 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	129,278					6.00
7.00	00700	OPERATION OF PLANT	21,739	107,539				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,121	1,121	223,159			8.00
9.00	00900	HOUSEKEEPING	2,177	2,177	0	36,835		9.00
10.00	01000	DIETARY	5,899	5,899	0	490	33,118	10.00
11.00	01100	CAFETERIA	2,250	2,250	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,557	3,557	0	122	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,846	1,846	0	306	0	14.00
15.00	01500	PHARMACY	1,545	1,545	0	367	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,689	2,689	0	306	0	16.00
17.00	01700	SOCIAL SERVICE	444	444	0	1,407	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,569	39,569	127,624	17,498	33,118	30.00
43.00	04300	NURSERY	1,447	1,447	0	918	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,240	13,240	6,695	3,671	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	865	865	10,734	491	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	306	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,910	3,910	22,316	979	0	54.00
60.00	06000	LABORATORY	3,822	3,822	0	1,224	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,003	3,003	11,158	612	0	65.00
66.00	06600	PHYSICAL THERAPY	3,399	3,399	11,158	1,836	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO 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	OTHER ANCILLARY - NUTRITIONAL	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	PARTIAL HOSPITALIZATION	5,103	5,103	0	0	0	90.01
91.00	09100	EMERGENCY	10,997	10,997	33,474	4,650	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,469	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	128,622	106,883	223,159	36,652	33,118	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	263	263	0	122	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	393	393	0	61	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,235,449	3,232,563	227,289	1,382,668	712,989	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.556529	30.059448	1.018507	37.536799	21.528746	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	126,640	406,985	25,343	55,926	130,925	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.979594	3.784534	0.113565	1.518284	3.953288	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/27/2016 10:36 am

		Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	67,086					11.00
13.00	01300	NURSING ADMINISTRATION	1,803	340,825				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	749	6,788	1,224,759			14.00
15.00	01500	PHARMACY	2,237	0	278	681,733		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,897	0	195	0	35,287	16.00
17.00	01700	SOCIAL SERVICE	1,157	0	12	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,888	131,731	155,900	12,105	31,889	30.00
43.00	04300	NURSERY	1,982	17,946	17,138	343	755	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,199	28,973	159,325	7,894	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,190	10,779	45,377	2,799	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	23,482	266	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,254	0	23,489	43,523	0	54.00
60.00	06000	LABORATORY	3,470	0	4,762	1	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,013	0	96,406	144	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,508	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	203,811	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	339,277	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	586,524	0	73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	0	0	148	15	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	1,936	17,528	275	0	0	90.01
91.00	09100	EMERGENCY	9,507	86,121	131,149	16,544	2,643	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	40,959	12,212	227	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	59,282	340,825	1,216,744	670,385	35,287	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	478	0	12	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,805	0	8,003	11,348	0	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	1,619	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	1,902	0	0	0	0	194.01
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)	944,180	1,008,518	436,379	280,924	1,273,724	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.074173	2.959049	0.356298	0.412073	36.096126	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	54,366	84,270	45,046	81,705	69,394	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.810393	0.247253	0.036779	0.119849	1.966560	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/27/2016 10:36 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT) 17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	293,078		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	131,731		30.00
43.00	04300	NURSERY	17,946		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	28,973		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,779		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	0		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
90.01	09001	PARTIAL HOSPITALIZATION	17,528		90.01
91.00	09100	EMERGENCY	86,121		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	293,078		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0		194.01
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)	475,344		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.621903		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,448		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.052710		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/27/2016 10:36 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,347,543		14,347,543	7,959	14,355,502	30.00
43.00	04300	NURSERY	1,324,610		1,324,610	0	1,324,610	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,941,025		2,941,025	0	2,941,025	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	848,775		848,775	0	848,775	52.00
53.00	05300	ANESTHESIOLOGY	49,868		49,868	0	49,868	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,221,639		3,221,639	0	3,221,639	54.00
60.00	06000	LABORATORY	3,782,505		3,782,505	0	3,782,505	60.00
65.00	06500	RESPIRATORY THERAPY	1,744,047	0	1,744,047	1,119	1,745,166	65.00
66.00	06600	PHYSICAL THERAPY	774,197	0	774,197	0	774,197	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	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	324,551		324,551	0	324,551	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	540,270		540,270	0	540,270	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,053,855		2,053,855	0	2,053,855	73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	116,239		116,239	0	116,239	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	1,231,254		1,231,254	0	1,231,254	90.01
91.00	09100	EMERGENCY	6,142,092		6,142,092	81,154	6,223,246	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,291,831		1,291,831		1,291,831	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,645,198		2,645,198		2,645,198	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	43,379,499	0	43,379,499	90,232	43,469,731	200.00
201.00		Less Observation Beds	1,291,831		1,291,831		1,291,831	201.00
202.00		Total (see instructions)	42,087,668	0	42,087,668	90,232	42,177,900	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/27/2016 10:36 am

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		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,110,196		8,110,196			30.00
43.00	04300	NURSERY	501,340		501,340			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	942,422	1,697,219	2,639,641	1.114176	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	349,247	103,845	453,092	1.873295	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	214,810	601,670	816,480	0.061077	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,382,181	8,383,586	9,765,767	0.329891	0.000000	54.00
60.00	06000	LABORATORY	2,690,215	13,045,443	15,735,658	0.240378	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,465,563	1,174,310	2,639,873	0.660656	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	63,532	2,324,862	2,388,394	0.324150	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	730,993	506,286	1,237,279	0.262310	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	323,370	580,775	904,145	0.597548	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	944,378	496,115	1,440,493	1.425800	0.000000	73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	300	19,660	19,960	5.823597	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	PARTIAL HOSPITALIZATION	377	995,581	995,958	1.236251	0.000000	90.01
91.00	09100	EMERGENCY	771,886	6,853,536	7,625,422	0.805476	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,975	672,748	678,723	1.903326	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,194,654	2,194,654			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,496,785	39,650,290	58,147,075			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	18,496,785	39,650,290	58,147,075			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/27/2016 10:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1.114176		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.873295		52.00
53.00	05300	ANESTHESIOLOGY	0.061077		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.329891		54.00
60.00	06000	LABORATORY	0.240378		60.00
65.00	06500	RESPIRATORY THERAPY	0.661080		65.00
66.00	06600	PHYSICAL THERAPY	0.324150		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.262310		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.597548		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.425800		73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	5.823597		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	PARTIAL HOSPITALIZATION	1.236251		90.01
91.00	09100	EMERGENCY	0.816118		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.903326		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I | Date/Time Prepared: 5/27/2016 10:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,217,491	0	1,217,491	9,779	124.50	30.00
43.00	NURSERY	49,564		49,564	585	84.72	43.00
200.00	Total (lines 30-199)	1,267,055		1,267,055	10,364		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,030	252,735				30.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	2,030	252,735				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/27/2016 10:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	323,926	2,639,641	0.122716	77,290	9,485	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,861	453,092	0.070319	4,177	294	52.00
53.00	05300	ANESTHESIOLOGY	1,549	816,480	0.001897	21,160	40	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	298,776	9,765,767	0.030594	396,056	12,117	54.00
60.00	06000	LABORATORY	110,506	15,735,658	0.007023	587,101	4,123	60.00
65.00	06500	RESPIRATORY THERAPY	86,794	2,639,873	0.032878	467,460	15,369	65.00
66.00	06600	PHYSICAL THERAPY	80,944	2,388,394	0.033891	29,531	1,001	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,079	1,237,279	0.007338	114,092	837	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,115	904,145	0.016717	74,867	1,252	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,837	1,440,493	0.057506	217,487	12,507	73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	846	19,960	0.042385	300	13	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	123,375	995,958	0.123876	0	0	90.01
91.00	09100	EMERGENCY	327,773	7,625,422	0.042984	208,508	8,963	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	109,560	678,723	0.161421	5,975	964	92.00
200.00		Total (lines 50-199)	1,602,941	47,340,885		2,204,004	66,965	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/27/2016 10:36 am

Title XVIII | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,779	0.00	2,030	0		30.00
43.00	04300	NURSERY	585	0.00	0	0		43.00
200.00		Total (lines 30-199)	10,364		2,030	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 10:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO 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	OTHER ANCILLARY - NUTRITIONAL	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	PARTIAL HOSPITALIZATION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 10:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,639,641	0.000000	0.000000	77,290	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	453,092	0.000000	0.000000	4,177	52.00
53.00	05300	ANESTHESIOLOGY	0	816,480	0.000000	0.000000	21,160	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,765,767	0.000000	0.000000	396,056	54.00
60.00	06000	LABORATORY	0	15,735,658	0.000000	0.000000	587,101	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,639,873	0.000000	0.000000	467,460	65.00
66.00	06600	PHYSICAL THERAPY	0	2,388,394	0.000000	0.000000	29,531	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,237,279	0.000000	0.000000	114,092	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	904,145	0.000000	0.000000	74,867	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,440,493	0.000000	0.000000	217,487	73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	0	19,960	0.000000	0.000000	300	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	0	995,958	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	7,625,422	0.000000	0.000000	208,508	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	678,723	0.000000	0.000000	5,975	92.00
200.00		Total (lines 50-199)	0	47,340,885			2,204,004	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 10:36 am

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		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	233,714	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	437	0		52.00
53.00	05300	ANESTHESIOLOGY	0	43,330	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	944,901	0		54.00
60.00	06000	LABORATORY	0	349,007	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	253,479	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	97,766	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	82,824	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	85,217	0		73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	PARTIAL HOSPITALIZATION	0	180,945	0		90.01
91.00	09100	EMERGENCY	0	565,372	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	115,045	0		92.00
200.00		Total (lines 50-199)	0	2,952,037	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/27/2016 10:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.114176	233,714	0	0	260,399	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.873295	437	0	0	819	52.00
53.00	05300	ANESTHESIOLOGY	0.061077	43,330	0	0	2,646	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.329891	944,901	0	532	311,714	54.00
60.00	06000	LABORATORY	0.240378	349,007	0	17	83,894	60.00
65.00	06500	RESPIRATORY THERAPY	0.660656	253,479	0	0	167,462	65.00
66.00	06600	PHYSICAL THERAPY	0.324150	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.262310	97,766	0	0	25,645	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.597548	82,824	0	0	49,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.425800	85,217	0	3,382	121,502	73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	5.823597	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	1.236251	180,945	0	0	223,693	90.01
91.00	09100	EMERGENCY	0.805476	565,372	0	0	455,394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.903326	115,045	0	0	218,968	92.00
200.00		Subtotal (see instructions)		2,952,037	0	3,931	1,921,627	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		2,952,037	0	3,931	1,921,627	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/27/2016 10:36 am

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	176		54.00
60.00	06000	LABORATORY	0	4		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,822		73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PARTIAL HOSPITALIZATION	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	5,002		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	5,002		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/27/2016 10:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,779	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,779	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)	8,899	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,030	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)	14,355,502	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)	14,355,502	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)	14,355,502	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)	1,467.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,980,020	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,980,020	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/27/2016 10:36 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	1,253,656	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,233,676	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)	252,735	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	66,965	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	319,700	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,913,976	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)	880	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,467.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,291,831	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/27/2016 10:36 am

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	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,217,491	14,355,502	0.084810	1,291,831	109,560	90.00
91.00	Nursing School cost	0	14,355,502	0.000000	1,291,831	0	91.00
92.00	Allied health cost	0	14,355,502	0.000000	1,291,831	0	92.00
93.00	All other Medical Education	0	14,355,502	0.000000	1,291,831	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/27/2016 10:36 am

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		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		1,860,475		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.114176	77,290	86,115	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.873295	4,177	7,825	52.00
53.00	05300	ANESTHESIOLOGY	0.061077	21,160	1,292	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.329891	396,056	130,655	54.00
60.00	06000	LABORATORY	0.240378	587,101	141,126	60.00
65.00	06500	RESPIRATORY THERAPY	0.661080	467,460	309,028	65.00
66.00	06600	PHYSICAL THERAPY	0.324150	29,531	9,572	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.262310	114,092	29,927	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.597548	74,867	44,737	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.425800	217,487	310,093	73.00
76.00	03950	OTHER ANCILLARY - NUTRITIONAL	5.823597	300	1,747	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	1.236251	0	0	90.01
91.00	09100	EMERGENCY	0.816118	208,508	170,167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.903326	5,975	11,372	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,204,004	1,253,656	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)		2,204,004		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 5/27/2016 10:36 am

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		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,308,809		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		0		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)		53,565		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)		108.59		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		26.38		30.00
31.00	Percentage of Medicaid patient days (see instructions)		64.79		31.00
32.00	Sum of lines 30 and 31		91.17		32.00
33.00	Allowable disproportionate share percentage (see instructions)		64.43		33.00
34.00	Disproportionate share adjustment (see instructions)		371,892		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 5/27/2016 10:36 am

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			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)		0.000175581	0.000174231	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,342,780	1,116,149	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,004,326	280,562	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,284,888		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		4,019,154		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)		4,019,154		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		224,167		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		4,243,321		59.00
60.00	Primary payer payments		1,408		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		4,241,913		61.00
62.00	Deductibles billed to program beneficiaries		369,939		62.00
63.00	Coinsurance billed to program beneficiaries		16,955		63.00
64.00	Allowable bad debts (see instructions)		302,525		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		196,641		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		252,876		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4,051,660		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			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)		1,462		70.93
70.94	HRR adjustment amount (see instructions)		-10,334		70.94
70.95	Recovery of accelerated depreciation		0		70.95

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			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,042,788		71.00
71.01	Sequestration adjustment (see instructions)		80,856		71.01
72.00	Interim payments		3,682,069		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)		279,863		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140077	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/27/2016 10:36 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,002	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,921,627	2.00
3.00	PPS payments	967,147	3.00
4.00	Outlier payment (see instructions)	56,477	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.878	5.00
6.00	Line 2 times line 5	1,687,189	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	60.67	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)	5,002	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	3,931	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)	3,931	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	3,931	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	1,071	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	3,931	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	1,023,624	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	229,271	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)	798,284	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)	798,284	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	798,284	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)	160,569	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	104,370	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	107,843	36.00
37.00	Subtotal (see instructions)	902,654	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	902,654	40.00
40.01	Sequestration adjustment (see instructions)	18,053	40.01
41.00	Interim payments	838,872	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	45,729	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: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2016 10:36 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,753,270		878,756	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	08/20/2015	71,201	08/20/2015	39,884	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)		-71,201		-39,884	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)		3,682,069		838,872	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		279,863		45,729	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,961,932		884,601	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140077	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/27/2016 10:36 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	2,434	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,030	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	8,899	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	58,147,075	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,553,302	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)	132,260	8.00
9.00	Sequestration adjustment amount (see instructions)	2,645	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	129,615	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	129,615	32.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/27/2016 10:36 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,459,854	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	17,358,407	0	0	0	4.00
5.00	Other receivable	1,459,779	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,230,130	0	0	0	6.00
7.00	Inventory	454,925	0	0	0	7.00
8.00	Prepaid expenses	411,761	0	0	0	8.00
9.00	Other current assets	1,362,492	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)	10,277,088	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,192,647	0	0	0	12.00
13.00	Land improvements	674,674	0	0	0	13.00
14.00	Accumulated depreciation	-597,318	0	0	0	14.00
15.00	Buildings	30,075,404	0	0	0	15.00
16.00	Accumulated depreciation	-13,149,949	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	21,238,993	0	0	0	19.00
20.00	Accumulated depreciation	-18,471,659	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	21,962,792	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	604,998	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,246,299	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,851,297	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	34,091,177	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,131,288	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,546,971	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	449,715	0	0	0	40.00
41.00	Deferred income	35,389	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	508,180	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,671,543	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,587,881	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,530,816	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	13,118,697	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	20,790,240	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	13,300,937				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	13,300,937	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	34,091,177	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/27/2016 10:36 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		13,063,003		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		82,451				2.00
3.00	Total (sum of line 1 and line 2)		13,145,454		0		3.00
4.00	RESTRICTED GRANTS	249,847		0		0	4.00
5.00	CONTRIBUTIONS FROM SOUTHERN ILLINOIS	16,370		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		266,217		0		10.00
11.00	Subtotal (line 3 plus line 10)		13,411,671		0		11.00
12.00	DECREASE IN VALUE OF BENEFICIAL INTE	54,864		0		0	12.00
13.00	NET ASSETS RELEASED FROM OPERATIONS	55,870		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		110,734		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,300,937		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	RESTRICTED GRANTS		0			4.00
5.00	CONTRIBUTIONS FROM SOUTHERN ILLINOIS		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	DECREASE IN VALUE OF BENEFICIAL INTE		0			12.00
13.00	NET ASSETS RELEASED FROM OPERATIONS		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/27/2016 10:36 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	8,611,536		8,611,536	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,611,536		8,611,536	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,611,536		8,611,536	17.00
18.00	Ancillary services	9,107,010	28,933,772	38,040,782	18.00
19.00	Outpatient services	778,238	8,521,865	9,300,103	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		2,194,654	2,194,654	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS PRIVATE OFFICES	1,483,473	6,777,276	8,260,749	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	19,980,257	46,427,567	66,407,824	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		56,310,722		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)		56,310,722		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140077	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prepared: 5/27/2016 10:36 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	66,407,824	1.00
2.00	Less contractual allowances and discounts on patients' accounts	11,437,454	2.00
3.00	Net patient revenues (line 1 minus line 2)	54,970,370	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,310,722	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,340,352	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	251,525	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	244,631	14.00
15.00	Revenue from rental of living quarters	24,595	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	47,978	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	33,924	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	59,736	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER - EHR REVENUE	399,788	24.00
24.01	OTHER - RELATED PARTY	87,946	24.01
24.02	OTHER - TRANSPORTATION	3,186	24.02
24.03	MISCELLANEOUS	214,630	24.03
25.00	Total other income (sum of lines 6-24)	1,367,939	25.00
26.00	Total (line 5 plus line 25)	27,587	26.00
27.00	GAIN/LOSS RESTRICTED	-54,864	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-54,864	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	82,451	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140077 | HHA CCN: 147315 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H | Date/Time Prepared: 5/27/2016 10:36 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		43,926	43,926	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	380,877	27,873	39,671	0	46,202	494,623	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	695,203	50,876	31,729	0	0	777,808	6.00
7.00	Physical Therapy	206,043	15,078	8,706	0	0	229,827	7.00
8.00	Occupational Therapy	12,185	892	820	86,840	0	100,737	8.00
9.00	Speech Pathology	8,138	596	364	0	0	9,098	9.00
10.00	Medical Social Services	6,083	445	142	0	0	6,670	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	227	227	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,308,529	95,760	81,432	86,840	90,355	1,662,916	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	43,926	0	43,926			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	494,623	-3,965	490,658			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	36,775	814,583	0	814,583			6.00
7.00	Physical Therapy	0	229,827	0	229,827			7.00
8.00	Occupational Therapy	0	100,737	0	100,737			8.00
9.00	Speech Pathology	0	9,098	0	9,098			9.00
10.00	Medical Social Services	0	6,670	0	6,670			10.00
11.00	Home Health Aide	0	0	0	0			11.00
12.00	Supplies (see instructions)	0	227	0	227			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	36,775	1,699,691	-3,965	1,695,726			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 140077 HHA CCN: 147315 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-1 Part I Date/Time Prepared: 5/27/2016 10:36 am

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	43,926	43,926				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	490,658	17,429	0	0	0	508,087	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	814,583	18,019	0	0	0	832,602	6.00
7.00	Physical Therapy	229,827	4,414	0	0	0	234,241	7.00
8.00	Occupational Therapy	100,737	0	0	0	0	100,737	8.00
9.00	Speech Pathology	9,098	166	0	0	0	9,264	9.00
10.00	Medical Social Services	6,670	3,892	0	0	0	10,562	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	227	6	0	0	0	233	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,695,726	43,926	0	0	0	1,695,726	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	508,087		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	356,197	1,188,799	6.00
7.00	Physical Therapy	100,211	334,452	7.00
8.00	Occupational Therapy	43,097	143,834	8.00
9.00	Speech Pathology	3,963	13,227	9.00
10.00	Medical Social Services	4,519	15,081	10.00
11.00	Home Health Aide	0	0	11.00
12.00	Supplies (see instructions)	100	333	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		1,695,726	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140077 HHA CCN: 147315 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-1 Part II Date/Time Prepared: 5/27/2016 10:36 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	1,614,450				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	640,591	0	0	0	-508,087	1,187,639	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	662,249	0	0	0	0	832,602	6.00
7.00	Physical Therapy	162,245	0	0	0	0	234,241	7.00
8.00	Occupational Therapy	0	0	0	0	0	100,737	8.00
9.00	Speech Pathology	6,095	0	0	0	0	9,264	9.00
10.00	Medical Social Services	143,043	0	0	0	0	10,562	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	227	0	0	0	0	233	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,614,450	0	0	0	-508,087	1,187,639	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	43,926	0	0	0		508,087	25.00
26.00	Unit Cost Multiplier	0.027208	0.000000	0.000000	0.000000		0.427813	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140077 HHA CCN: 147315 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part I Date/Time Prepared: 5/27/2016 10:36 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	0	84,355	84,355	19,917	1.00
2.00	Skilled Nursing Care	1,188,799	0	0	162,114	1,350,913	318,970	2.00
3.00	Physical Therapy	334,452	0	0	45,633	380,085	89,743	3.00
4.00	Occupational Therapy	143,834	0	0	2,699	146,533	34,598	4.00
5.00	Speech Pathology	13,227	0	0	1,802	15,029	3,549	5.00
6.00	Medical Social Services	15,081	0	0	1,347	16,428	3,879	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	333	0	0	0	333	79	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,695,726	0	0	297,950	1,993,676	470,735	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	0	0	55,142	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	55,142	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140077 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part I | Date/Time Prepared: 5/27/2016 10:36 am

HHA CCN: 147315 | Home Health Agency I | PPS

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		13.00	14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	57,743	4,351	0	0	0	221,508	1.00
2.00	Skilled Nursing Care	48,857	0	0	0	0	1,718,740	2.00
3.00	Physical Therapy	12,671	0	0	0	0	482,499	3.00
4.00	Occupational Therapy	1,192	0	0	0	0	182,323	4.00
5.00	Speech Pathology	530	0	0	0	0	19,108	5.00
6.00	Medical Social Services	207	0	0	0	0	20,514	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	412	8.00
9.00	Drugs	0	0	94	0	0	94	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	121,200	4,351	94	0	0	2,645,198	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	221,508					1.00
2.00	Skilled Nursing Care	0	1,718,740	157,080	1,875,820			2.00
3.00	Physical Therapy	0	482,499	44,097	526,596			3.00
4.00	Occupational Therapy	0	182,323	16,663	198,986			4.00
5.00	Speech Pathology	0	19,108	1,746	20,854			5.00
6.00	Medical Social Services	0	20,514	1,875	22,389			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	412	38	450			8.00
9.00	Drugs	0	94	9	103			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	0	2,645,198	221,508	2,645,198			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.091393				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140077 HHA CCN: 147315 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part II Date/Time Prepared: 5/27/2016 10:36 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	0	0	380,878	0	84,355	0	1.00
2.00	Skilled Nursing Care	0	0	731,978	0	1,350,913	0	2.00
3.00	Physical Therapy	0	0	206,043	0	380,085	0	3.00
4.00	Occupational Therapy	0	0	12,185	0	146,533	0	4.00
5.00	Speech Pathology	0	0	8,138	0	15,029	0	5.00
6.00	Medical Social Services	0	0	6,083	0	16,428	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	333	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	1,345,305		1,993,676	0	20.00
21.00	Total cost to be allocated	0	0	297,950		470,735	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.221474		0.236114	0.000000	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	1,469	0	0	19,514	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	16,511	2.00
3.00	Physical Therapy	0	0	0	0	0	4,282	3.00
4.00	Occupational Therapy	0	0	0	0	0	403	4.00
5.00	Speech Pathology	0	0	0	0	0	179	5.00
6.00	Medical Social Services	0	0	0	0	0	70	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	1,469	0	0	40,959	20.00
21.00	Total cost to be allocated	0	0	55,142	0	0	121,200	21.00
22.00	Unit cost multiplier	0.000000	0.000000	37.537100	0.000000	0.000000	2.959057	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140077 HHA CCN: 147315 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part II Date/Time Prepared: 5/27/2016 10:36 am

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	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)			
		14.00	15.00	16.00	17.00			
1.00	Administrative and General	12,212	0	0	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	227	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19)	12,212	227	0	0			20.00
21.00	Total cost to be allocated	4,351	94	0	0			21.00
22.00	Unit cost multiplier	0.356289	0.414097	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140077 | HHA CCN: 147315 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 5/27/2016 10:36 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,875,820		1,875,820	9,320	201.27	1.00
2.00	Physical Therapy	3.00	526,596	0	526,596	3,686	142.86	2.00
3.00	Occupational Therapy	4.00	198,986	0	198,986	913	217.95	3.00
4.00	Speech Pathology	5.00	20,854	0	20,854	169	123.40	4.00
5.00	Medical Social Services	6.00	22,389		22,389	51	439.00	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		2,644,645	0	2,644,645	14,139		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		41180	0	1,008			8.00
9.00	Physical Therapy		41180	0	822			9.00
10.00	Occupational Therapy		41180	0	194			10.00
11.00	Speech Pathology		41180	0	8			11.00
12.00	Medical Social Services		41180	0	15			12.00
13.00	Home Health Aide		41180	0	0			13.00
14.00	Total (sum of lines 8-13)			0	2,047			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	450	0	450	528	0.852273	15.00
16.00	Cost of Drugs	9.00	103	0	103	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,008		0	202,880		1.00
2.00	Physical Therapy	0	822		0	117,431		2.00
3.00	Occupational Therapy	0	194		0	42,282		3.00
4.00	Speech Pathology	0	8		0	987		4.00
5.00	Medical Social Services	0	15		0	6,585		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	0	2,047		0	370,165		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 140077 | HHA CCN: 147315 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 5/27/2016 10:36 am

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	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	528	0	0	450	0	15.00
16.00	Cost of Drugs	0	0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	202,880	1.00
2.00	Physical Therapy	117,431	2.00
3.00	Occupational Therapy	42,282	3.00
4.00	Speech Pathology	987	4.00
5.00	Medical Social Services	6,585	5.00
6.00	Home Health Aide	0	6.00
7.00	Total (sum of lines 1-6)	370,165	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
9.00	Physical Therapy		9.00
10.00	Occupational Therapy		10.00
11.00	Speech Pathology		11.00
12.00	Medical Social Services		12.00
13.00	Home Health Aide		13.00
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140077 HHA CCN: 147315 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part II Date/Time Prepared: 5/27/2016 10:36 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.324150	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.000000	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.000000	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.262310	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	1.425800	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140077 | HHA CCN: 147315 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/27/2016 10:36 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	377,677	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	11,744	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	389,421	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	389,421	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	389,421	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	389,421	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	389,421	31.00
31.01	Sequestration adjustment (see instructions)	0	7,788	31.01
32.00	Interim payments (see instructions)	0	381,633	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 140077 | HHA CCN: 147315 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-5 | Date/Time Prepared: 5/27/2016 10:36 am

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		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		381,633	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		381,633	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		381,633	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140077	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/27/2016 10:36 am
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		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	183,539	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	3,425	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)	24.63	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)	26.38	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	64.79	8.00
9.00	Sum of lines 7 and 8	91.17	9.00
10.00	Allowable disproportionate share percentage (see instructions)	20.27	10.00
11.00	Disproportionate share adjustment (see instructions)	37,203	11.00
12.00	Total prospective capital payments (see instructions)	224,167	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