

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: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/20/2015 1:35 pm
--	----------------------	---------------------------------------	--

PART I - COST REPORT STATUS

Provider use only

1. Electronically filed cost report Date: 11/20/2015 Time: 1:35 pm

2. Manually submitted cost report

3. If this is an amended report enter the number of times the provider resubmitted this cost report

4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended

6. Date Received: Contractor No.

7. Initial Report for this Provider CCN

8. Final Report for this Provider CCN

9. Final Report for this Provider CCN

10. NPR Date: Contractor's Vendor Code: 4

11. 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 NORTHERN ILLINOIS MEDICAL CENTER (140116) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 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.

Encryption Information
 ECR: Date: 11/20/2015 Time: 1:35 pm
 cVvaUH8C: nCN: I35sWb5pqYpyTuxw0
 0Cmqa0b0zabpMLVML.1vR6STXgJDX4
 jwl Z1L1PJ00c1u: 0
 PI: Date: 11/20/2015 Time: 1:35 pm
 RAdPWU9603xZj 8xcj gxnAxK1wu3040
 Lj AJyOW63k8LD36j J9HsuzdLaRzWYc
 z7720gj HLx0V: tKe

(Signed) _____
 Officer or Administrator of Provider(s)
 EXECUTIVE VP, CFO AND CIO
 Title _____
 11/24/2015
 Date _____

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	1,497,890	57,760	-9,193	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	17,731	29		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	-288		0	9.00
200.00 Total	0	1,515,621	57,501	-9,193	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 140116		Period: From 07/01/2014 To 06/30/2015		Worksheet S-2 Part I Date/Time Prepared: 11/20/2015 1:32 pm			
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 4201 MEDICAL CENTER DRIVE			PO Box:						1.00		
2.00	City: MCHENRY			State: IL		Zip Code: 60050-		County: MCHENRY		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		NORTHERN ILLINOIS MEDICAL CENTER		140116	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF		NIMC REHABILITATION UNIT		14T116	16974	5	07/01/1985	N	P	O	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		NIMC HOME HEALTH AGENCY		147455	16974		07/01/1986	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)						07/01/2014	06/30/2015		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)						N	N		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						1	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.			2,626	791	23	0	2,825	211	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.			213	50	0	0	50		25.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/20/2015 1:32 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140116		Period: From 07/01/2014 To 06/30/2015		Worksheet S-2 Part I Date/Time Prepared: 11/20/2015 1:32 pm	
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/20/2015 1:32 pm		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
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.			Y		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0
				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.			Y	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140116		Period: From 07/01/2014 To 06/30/2015		Worksheet S-2 Part I Date/Time Prepared: 11/20/2015 1:32 pm	
		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)	N					106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N					108.00
		Physical	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.	N					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	1,610,021	941,354			0	118.01
						1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N			118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y			121.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/20/2015 1:32 pm			
		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	14H122	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: NAME: CENTEGRA HEALTH SYSTEM	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00131			
142.00	Street: STREET: STREET: 385 MILLENNIUM DR	PO Box:		142.00			
143.00	City: CRYSTAL LAKE	State: IL	Zip Code: 60012-3761	143.00			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00		
				1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00			
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00			
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00			
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00			
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
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	N	161.00	
				1.00			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N	165.00		
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
				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)			0.75	169.00		
				Beginni ng	Endi ng		
				1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			07/01/2014	09/30/2014	170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/20/2015 1:32 pm
				1.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N 171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 11/20/2015 1:32 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	10/19/2015	Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 11/20/2015 1:32 pm	
	Description	Part A		Part B	
		Y/N	Date	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 relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
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.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	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.			N	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.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	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.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ANNA	BURACKER		41.00
42.00	Enter the employer/company name of the cost report preparer.	CENTEGRA HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(815)759-8037	ABURACKER@CENTEGRA.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-2
Part II
Date/Time Prepared:
11/20/2015 1:32 pm

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	10/19/2015	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR REIMBURSEMENT ANALYST	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

VOLUNTARY CONTACT INFORMATION

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-2
Part V
Date/Time Prepared:
11/20/2015 1:32 pm

		1.00	
Cost Report Preparer Contact Information			
1.00	First Name	ANNA	1.00
2.00	Last Name	BURACKER	2.00
3.00	Title	SR. REIMBURSEMENT ANALYST	3.00
4.00	Employer	CENTEGRA HEALTH SYSTEM	4.00
5.00	Phone Number	(815)759-8037	5.00
6.00	E-mail Address	ABURACKER@CENTEGRA.COM	6.00
7.00	Department	FINANCE	7.00
8.00	Mailing Address 1	527 W. SOUTH ST.	8.00
9.00	Mailing Address 2		9.00
10.00	City	WOODSTOCK	10.00
11.00	State	IL	11.00
12.00	Zip	60098	12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name	DAVID	13.00
14.00	Last Name	TOMLINSON	14.00
15.00	Title	EXECUTIVE VP, CFO & CIO	15.00
16.00	Employer	CENTEGRA HEALTH SYSTEM	16.00
17.00	Phone Number	(815)788-5800	17.00
18.00	E-mail Address	DTOMLINSON@CENTEGRA.COM	18.00
19.00	Department	ADMINISTRATION	19.00
20.00	Mailing Address 1	385 MILLENNIUM DRIVE	20.00
21.00	Mailing Address 2		21.00
22.00	City	CRYSTAL LAKE	22.00
23.00	State	IL	23.00
24.00	Zip	60012	24.00

HFS Supplemental Information		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part IX Date/Time Prepared: 11/20/2015 1:32 pm	
			Title V	Title XIX	
			1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	3.00
			Inpatient	Outpatient	
			1.00	2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	5.00
			Title V	Title XIX	
			1.00	2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	6.00
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2015 1:32 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	133	48,421	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)		133	48,421	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	18	6,570	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		151	54,991	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	22	8,030		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	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)		173				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)		6	2,190			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: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2015 1:32 pm

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)	16,196	1,438	30,739			1.00
2.00 HMO and other (see instructions)	2,192	3,833				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	367	100				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)	16,196	1,438	30,739			7.00
8.00 INTENSIVE CARE UNIT	2,608	377	4,499			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		882	3,608			13.00
14.00 Total (see instructions)	18,804	2,697	38,846	0.00	1,002.96	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	5,013	241	6,721	0.00	34.34	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	23,226	1,977	32,020	0.00	40.66	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	1,077.96	27.00
28.00 Observation Bed Days		223	4,276			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	211	516			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: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2015 1:32 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	4,209	546	9,304	1.00
2.00 HMO and other (see instructions)			436	881		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	4,209	546	9,304	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	369	20	499	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: 140116		Period: From 07/01/2014 To 06/30/2015		Worksheet S-3 Part II Date/Time Prepared: 11/20/2015 1:32 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	90,205,764	-15,905,512	74,300,252	2,242,154.00	33.14	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		5,224,888	391,241	5,616,129	164,084.00	34.23	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		7,023,942	0	7,023,942	199,962.95	35.13	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		580,230	0	580,230	2,289.21	253.46	13.00
14.00	Home office salaries & wage-related costs		21,943,742	0	21,943,742	393,864.00	55.71	14.00
15.00	Home office: Physician Part A - Administrative		34,964	0	34,964	386.00	90.58	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)		18,325,613	0	18,325,613			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,463,735	0	1,463,735			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	1,251,798	-1,251,798	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	20,410,778	-17,814,010	2,596,768	114,580.00	22.66	27.00
28.00	Administrative & General under contract (see inst.)		3,184,873	0	3,184,873	62,293.56	51.13	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,454,112	20,680	1,474,792	57,994.00	25.43	30.00
31.00	Laundry & Linen Service	8.00	43,433	895	44,328	2,550.00	17.38	31.00
32.00	Housekeeping	9.00	1,505,028	25,346	1,530,374	94,942.00	16.12	32.00
33.00	Housekeeping under contract (see instructions)		151,467	0	151,467	5,488.25	27.60	33.00
34.00	Dietary	10.00	1,552,666	-757,224	795,442	45,400.00	17.52	34.00
35.00	Dietary under contract (see instructions)		358,544	0	358,544	10,610.25	33.79	35.00
36.00	Cafeteria	11.00	0	780,420	780,420	39,160.00	19.93	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,843,847	15,743	1,859,590	42,915.00	43.33	38.00
39.00	Central Services and Supply	14.00	454,494	8,369	462,863	22,891.00	20.22	39.00
40.00	Pharmacy	15.00	3,399,411	51,029	3,450,440	80,199.00	43.02	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part II
Date/Time Prepared:
11/20/2015 1:32 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
41.00	Medical Records & Medical Records Library	16.00	440	0	440	8.00	55.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part III
Date/Time Prepared:
11/20/2015 1:32 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	93,900,648	-15,905,512	77,995,136	2,320,546.06	33.61	1.00
2.00	Excluded area salaries (see instructions)	5,224,888	391,241	5,616,129	164,084.00	34.23	2.00
3.00	Subtotal salaries (line 1 minus line 2)	88,675,760	-16,296,753	72,379,007	2,156,462.06	33.56	3.00
4.00	Subtotal other wages & related costs (see inst.)	29,582,878	0	29,582,878	596,502.16	49.59	4.00
5.00	Subtotal wage-related costs (see inst.)	18,325,613	0	18,325,613	0.00	25.32	5.00
6.00	Total (sum of lines 3 thru 5)	136,584,251	-16,296,753	120,287,498	2,752,964.22	43.69	6.00
7.00	Total overhead cost (see instructions)	35,610,891	-18,920,550	16,690,341	579,031.06	28.82	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet S-3 Part IV Date/Time Prepared: 11/20/2015 1:32 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			1,192,554 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			17,054 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)			9,708,043 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			499,530 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			176,760 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)			728,023 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			1,475,648 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			5,114,558 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			79,904 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			425,266 22.00
23.00	Tuition Reimbursement			372,008 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			19,789,348 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: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part V
Date/Time Prepared:
11/20/2015 1:32 pm

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	7,023,942	0	1.00
2.00	Hospital	7,023,942	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 140116 Component CCN: 147455		Period: From 07/01/2014 To 06/30/2015		Worksheet S-4 Date/Time Prepared: 11/20/2015 1:32 pm	
				Home Health Agency I		PPS	
						1.00	
0.00	County					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	3,428	68	192	3,688 1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	1,361.00	121.00	467.00	1,949.00 2.00	
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		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		11.34	0.00	11.34 3.00	
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00 4.00	
5.00	Other Administrative Personnel			0.00	0.00	0.00 5.00	
6.00	Direct Nursing Service			18.06	0.00	18.06 6.00	
7.00	Nursing Supervisor			0.00	0.00	0.00 7.00	
8.00	Physical Therapy Service			6.23	0.00	6.23 8.00	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00 9.00	
10.00	Occupational Therapy Service			1.02	0.00	1.02 10.00	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00 11.00	
12.00	Speech Pathology Service			0.46	0.00	0.46 12.00	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00 13.00	
14.00	Medical Social Service			0.57	0.00	0.57 14.00	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00 15.00	
16.00	Home Health Aide			2.97	0.00	2.97 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.			2		19.00	
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			16974		20.00	
20.01				29404		20.01	
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	10,159	1,254	298	161	11,872 21.00	
22.00	Skilled Nursing Visit Charges	2,066,270	252,950	62,120	32,720	2,414,060 22.00	
23.00	Physical Therapy Visits	6,862	200	138	68	7,268 23.00	
24.00	Physical Therapy Visit Charges	1,409,560	41,000	28,815	14,045	1,493,420 24.00	
25.00	Occupational Therapy Visits	995	63	3	18	1,079 25.00	
26.00	Occupational Therapy Visit Charges	203,360	12,915	615	3,690	220,580 26.00	
27.00	Speech Pathology Visits	493	31	0	16	540 27.00	
28.00	Speech Pathology Visit Charges	101,065	6,355	0	3,280	110,700 28.00	
29.00	Medical Social Service Visits	77	3	3	1	84 29.00	
30.00	Medical Social Service Visit Charges	19,010	750	750	250	20,760 30.00	
31.00	Home Health Aide Visits	1,994	374	4	11	2,383 31.00	
32.00	Home Health Aide Visit Charges	219,230	41,140	440	1,210	262,020 32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	20,580	1,925	446	275	23,226 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)	4,018,495	355,110	92,740	55,195	4,521,540 35.00	
36.00	Total Number of Episodes (standard/non outlier)	1,296		155	19	1,470 36.00	
37.00	Total Number of Outlier Episodes		38		2	40 37.00	
38.00	Total Non-Routine Medical Supply Charges	172,458	27,794	8,684	248	209,184 38.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet S-10 Date/Time Prepared: 11/20/2015 1:32 pm
---	----------------------	---	---

			1.00			
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.285099	1.00		
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		11,006,687	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		61,770	5.00		
6.00	Medicaid charges		89,837,515	6.00		
7.00	Medicaid cost (line 1 times line 6)		25,612,586	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)		14,544,129	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)		14,544,129	19.00		
			Uninsured patients	Insured patients		
			1.00	2.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility		7,290,886	1,323,199	8,614,085	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		2,078,624	377,243	2,455,867	21.00
22.00	Partial payment by patients approved for charity care		315,167	246,983	562,150	22.00
23.00	Cost of charity care (line 21 minus line 22)		1,763,457	130,260	1,893,717	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)				8,594,280	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)				778,398	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)				7,815,882	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)				2,228,300	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				4,122,017	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				18,666,146	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet A
Date/Time Prepared:
11/20/2015 1:32 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		9,515,883	9,515,883	-2,248,252	7,267,631	1.00
2.00	00200		0	0	6,251,667	6,251,667	2.00
4.00	00400	1,251,798	17,737,688	18,989,486	-57,004	18,932,482	4.00
5.00	00500	20,410,778	42,658,972	63,069,750	-3,611,411	59,458,339	5.00
7.00	00700	1,454,112	2,644,660	4,098,772	20,680	4,119,452	7.00
8.00	00800	43,433	797,143	840,576	895	841,471	8.00
9.00	00900	1,505,028	827,144	2,332,172	25,311	2,357,483	9.00
10.00	01000	1,552,666	1,909,168	3,461,834	-1,460,356	2,001,478	10.00
11.00	01100	0	0	0	1,483,552	1,483,552	11.00
13.00	01300	1,843,847	280,983	2,124,830	-152,088	1,972,742	13.00
14.00	01400	454,494	1,225,852	1,680,346	5,296	1,685,642	14.00
15.00	01500	3,399,411	14,952,485	18,351,896	-13,975,117	4,376,779	15.00
16.00	01600	440	3,201,976	3,202,416	0	3,202,416	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	17,718,578	3,773,919	21,492,497	-2,671,171	18,821,326	30.00
31.00	03100	3,904,647	780,703	4,685,350	188,555	4,873,905	31.00
41.00	04100	2,339,368	156,094	2,495,462	329,490	2,824,952	41.00
43.00	04300	0	0	0	1,641,041	1,641,041	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	7,034,985	14,004,701	21,039,686	-9,881,827	11,157,859	50.00
51.00	05100	1,057,400	122,895	1,180,295	-11,502	1,168,793	51.00
52.00	05200	0	0	0	2,792,835	2,792,835	52.00
53.00	05300	40,964	469,892	510,856	-17,524	493,332	53.00
54.00	05400	4,658,029	2,702,777	7,360,806	15,069	7,375,875	54.00
55.00	05500	1,866,620	751,262	2,617,882	30,557	2,648,439	55.00
56.00	05600	559,642	891,586	1,451,228	11,788	1,463,016	56.00
57.00	05700	698,865	297,564	996,429	-15,546	980,883	57.00
58.00	05800	283,867	131,877	415,744	5,581	421,325	58.00
59.00	05900	1,245,127	5,254,462	6,499,589	-4,436,360	2,063,229	59.00
60.00	06000	2,644	5,663,547	5,666,191	0	5,666,191	60.00
65.00	06500	1,242,764	434,834	1,677,598	-53,078	1,624,520	65.00
66.00	06600	5,213,850	1,177,389	6,391,239	81,927	6,473,166	66.00
67.00	06700	1,066,749	80,861	1,147,610	11,380	1,158,990	67.00
68.00	06800	442,232	7,328	449,560	6,955	456,515	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	122,383	87,145	209,528	-1,093	208,435	70.01
71.00	07100	0	0	0	5,853,181	5,853,181	71.00
72.00	07200	0	0	0	9,886,484	9,886,484	72.00
73.00	07300	0	0	0	13,997,813	13,997,813	73.00
76.00	03140	415,180	38,159	453,339	6,038	459,377	76.00
76.97	07697	514,528	219,551	734,079	11,581	745,660	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	404,773	5,599,309	6,004,082	-34,085	5,969,997	90.00
90.01	09001	100,506	41,279	141,785	743	142,528	90.01
91.00	09100	4,136,072	1,451,076	5,587,148	-4,174	5,582,974	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	334,464	867,457	1,201,921	-400,343	801,578	97.00
101.00	10100	2,883,518	444,448	3,327,966	59,124	3,387,090	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		3,684,173	3,684,173	-3,684,173	0	113.00
118.00		90,203,762	144,886,242	235,090,004	2,439	235,092,443	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.01	19201	2,002	4,321	6,323	209	6,532	192.01
192.02	19202	0	8,062	8,062	-2,648	5,414	192.02
192.04	19204	0	0	0	0	0	192.04
200.00		90,205,764	144,898,625	235,104,389	0	235,104,389	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet A
Date/Time Prepared:
11/20/2015 1:32 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-3,684,045	3,583,586	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	6,251,667	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,382	18,929,100	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-19,989,584	39,468,755	5.00
7.00	00700	OPERATION OF PLANT	-474,427	3,645,025	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	841,471	8.00
9.00	00900	HOUSEKEEPING	-186,147	2,171,336	9.00
10.00	01000	DIETARY	0	2,001,478	10.00
11.00	01100	CAFETERIA	-951,598	531,954	11.00
13.00	01300	NURSING ADMINISTRATION	399,247	2,371,989	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,685,642	14.00
15.00	01500	PHARMACY	-582,767	3,794,012	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13,294	3,189,122	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,714,882	17,106,444	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,873,905	31.00
41.00	04100	SUBPROVIDER - I RF	0	2,824,952	41.00
43.00	04300	NURSERY	0	1,641,041	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-277,294	10,880,565	50.00
51.00	05100	RECOVERY ROOM	0	1,168,793	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,792,835	52.00
53.00	05300	ANESTHESIOLOGY	-23,599	469,733	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-257,417	7,118,458	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-41,517	2,606,922	55.00
56.00	05600	RADIOISOTOPE	0	1,463,016	56.00
57.00	05700	CT SCAN	0	980,883	57.00
58.00	05800	MRI	0	421,325	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,063,229	59.00
60.00	06000	LABORATORY	-521,316	5,144,875	60.00
65.00	06500	RESPIRATORY THERAPY	-50,927	1,573,593	65.00
66.00	06600	PHYSICAL THERAPY	-289,881	6,183,285	66.00
67.00	06700	OCCUPATIONAL THERAPY	-40,023	1,118,967	67.00
68.00	06800	SPEECH PATHOLOGY	0	456,515	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	208,435	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,853,181	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,886,484	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,997,813	73.00
76.00	03140	CARDIOLOGY	0	459,377	76.00
76.97	07697	CARDIAC REHABILITATION	-117,368	628,292	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-492,647	5,477,350	90.00
90.01	09001	DIABETES CENTER	-5,677	136,851	90.01
91.00	09100	EMERGENCY	-75,079	5,507,895	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	-1,362	800,216	97.00
101.00	10100	HOME HEALTH AGENCY	-51,869	3,335,221	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-29,446,855	205,645,588	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.01	19201	OCCUPATIONAL HEALTH	0	6,532	192.01
192.02	19202	FLIGHT FOR LIFE	0	5,414	192.02
192.04	19204	WELLNESS PROGRAM	0	0	192.04
200.00		TOTAL (SUM OF LINES 118-199)	-29,446,855	205,657,534	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet Non-CMS W
Date/Time Prepared:
11/20/2015 1:32 pm

Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
GENERAL SERVICE COST CENTERS			
1.00 CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00 ADMINISTRATIVE & GENERAL	00500		5.00
7.00 OPERATION OF PLANT	00700		7.00
8.00 LAUNDRY & LINEN SERVICE	00800		8.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
11.00 CAFETERIA	01100		11.00
13.00 NURSING ADMINISTRATION	01300		13.00
14.00 CENTRAL SERVICES & SUPPLY	01400		14.00
15.00 PHARMACY	01500		15.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
17.00 SOCIAL SERVICE	01700		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
41.00 SUBPROVIDER - IRF	04100		41.00
43.00 NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	05000		50.00
51.00 RECOVERY ROOM	05100		51.00
52.00 DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00 ANESTHESIOLOGY	05300		53.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
55.00 RADIOLOGY-THERAPEUTIC	05500		55.00
56.00 RADIOISOTOPE	05600		56.00
57.00 CT SCAN	05700		57.00
58.00 MRI	05800		58.00
59.00 CARDIAC CATHETERIZATION	05900		59.00
60.00 LABORATORY	06000		60.00
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
67.00 OCCUPATIONAL THERAPY	06700		67.00
68.00 SPEECH PATHOLOGY	06800		68.00
70.00 ELECTROENCEPHALOGRAPHY	07000		70.00
70.01 SLEEP LAB/NEUROLOGY	07001		70.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
76.00 RADIOLOGY	03140	CARDIOLOGY	76.00
76.97 CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	09000		90.00
90.01 DIABETES CENTER	09001		90.01
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
OTHER REIMBURSABLE COST CENTERS			
97.00 DURABLE MEDICAL EQUIP-SOLD	09700		97.00
101.00 HOME HEALTH AGENCY	10100		101.00
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE	11300		113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.01 OCCUPATIONAL HEALTH	19201		192.01
192.02 FLIGHT FOR LIFE	19202		192.02
192.04 WELLNESS PROGRAM	19204		192.04
200.00 TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6
Date/Time Prepared:
11/20/2015 1:32 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAPITAL RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00		6,251,327	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		36,996	2.00
			0	6,288,323	
B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	780,420	703,132	1.00
			780,420	703,132	
C - MED SUPPLIES & IMPLANTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,853,181	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,886,484	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
	0		0	15,739,665	
D - NURSERY					
1.00	NURSERY	43.00	941,047	530,248	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,786,310	1,006,525	2.00
			2,727,357	1,536,773	
E - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,040,071	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	340	2.00
	TOTALS		0	4,040,411	
F - CHARGABLE DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00		13,997,813	1.00
			0	13,997,813	
G - ATO RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	75,557	0	1.00
2.00	OPERATION OF PLANT	7.00	20,680	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	895	0	3.00
4.00	HOUSEKEEPING	9.00	25,346	0	4.00
5.00	DIETARY	10.00	23,196	0	5.00
6.00	NURSING ADMINISTRATION	13.00	15,743	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	8,369	0	7.00
8.00	PHARMACY	15.00	51,029	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	292,657	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	66,292	0	10.00
11.00	SUBPROVIDER - IRF	41.00	42,543	0	11.00
12.00	OPERATING ROOM	50.00	135,289	0	12.00
13.00	RECOVERY ROOM	51.00	17,806	0	13.00
14.00	ANESTHESIOLOGY	53.00	1,098	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	83,279	0	15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	35,764	0	16.00
17.00	RADIOISOTOPE	56.00	11,788	0	17.00
18.00	CT SCAN	57.00	11,504	0	18.00
19.00	MRI	58.00	6,955	0	19.00
20.00	CARDIAC CATHETERIZATION	59.00	20,901	0	20.00
21.00	RESPIRATORY THERAPY	65.00	17,565	0	21.00
22.00	PHYSICAL THERAPY	66.00	99,762	0	22.00
23.00	OCCUPATIONAL THERAPY	67.00	17,517	0	23.00

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6

Date/Time Prepared:
11/20/2015 1:32 pm

Increases						
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
24.00	SPEECH PATHOLOGY	68.00	7,564	0		24.00
25.00	SLEEP LAB/NEUROLOGY	70.01	1,564	0		25.00
26.00	CARDIOLOGY	76.00	9,586	0		26.00
27.00	CARDIAC REHABILITATION	76.97	12,436	0		27.00
28.00	CLINIC	90.00	9,266	0		28.00
29.00	DIABETES CENTER	90.01	1,370	0		29.00
30.00	EMERGENCY	91.00	62,502	0		30.00
31.00	DURABLE MEDICAL EQUIP-SOLD	97.00	6,642	0		31.00
32.00	HOME HEALTH AGENCY	101.00	59,124	0		32.00
33.00	OCCUPATIONAL HEALTH	192.01	209	0		33.00
			1,251,798	0		
H - CENTEGRA ALLOCATION						
1.00	ADMINISTRATIVE & GENERAL	5.00		15,888,012		1.00
				0	15,888,012	
I - CASE MANAGEMENT/SOCIAL SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	1,345,651	124,799		1.00
2.00	INTENSIVE CARE UNIT	31.00	193,700	17,964		2.00
3.00	SUBPROVIDER - IRF	41.00	289,365	26,836		3.00
4.00	NURSERY	43.00	155,339	14,407		4.00
	TOTALS		1,984,055	184,006		
J - WORKERS COMP INSURANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		1,194,794		1.00
				0	1,194,794	
K - SALARY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,500		1.00
				0	17,500	
500.00	Grand Total: Increases		6,743,630	59,590,429		500.00

RECLASSIFICATIONS

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6
Date/Time Prepared:
11/20/2015 1:32 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - CAPITAL RECLASS							
1.00	CAP REL COSTS-BLDG & FIXT	1.00		6,288,323		9	1.00
2.00			0	6,288,323			2.00
B - CAFETERIA RECLASS							
1.00	DIETARY	10.00	780,420	703,132			1.00
			780,420	703,132			
C - MED SUPPLIES & IMPLANTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,871		0	1.00
2.00	HOUSEKEEPING	9.00	0	35		0	2.00
3.00	NURSING ADMINISTRATION	13.00	0	167,831		0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,073		0	4.00
5.00	PHARMACY	15.00	0	28,333		0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	170,148		0	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	89,401		0	7.00
8.00	SUBPROVIDER - IRF	41.00	0	29,254		0	8.00
9.00	OPERATING ROOM	50.00	0	10,017,116		0	9.00
10.00	RECOVERY ROOM	51.00	0	29,308		0	10.00
11.00	ANESTHESIOLOGY	53.00	0	18,622		0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	68,210		0	12.00
13.00	RADIOLOGY-THERAPEUTIC	55.00	0	5,207		0	13.00
14.00	CT SCAN	57.00	0	27,050		0	14.00
15.00	MRI	58.00	0	1,374		0	15.00
16.00	CARDIAC CATHETERIZATION	59.00	0	4,457,261		0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	70,643		0	17.00
18.00	PHYSICAL THERAPY	66.00	0	17,835		0	18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	6,137		0	19.00
20.00	SPEECH PATHOLOGY	68.00	0	609		0	20.00
21.00	SLEEP LAB/NEUROLOGY	70.01	0	2,657		0	21.00
22.00	CARDIOLOGY	76.00	0	3,548		0	22.00
23.00	CARDIAC REHABILITATION	76.97	0	855		0	23.00
24.00	CLINIC	90.00	0	43,351		0	24.00
25.00	DIABETES CENTER	90.01	0	627		0	25.00
26.00	EMERGENCY	91.00	0	66,676		0	26.00
27.00	DURABLE MEDICAL EQUIP-SOLD	97.00	0	406,985		0	27.00
28.00	FLIGHT FOR LIFE	192.02	0	2,648		0	28.00
	TOTALS		0	15,739,665			
D - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	2,727,357	1,536,773			1.00
2.00			2,727,357	1,536,773			2.00
E - INTEREST EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	356,238		11	1.00
2.00	INTEREST EXPENSE	113.00	0	3,684,173		11	2.00
	TOTALS		0	4,040,411			
F - CHARGABLE DRUG COSTS							
1.00	PHARMACY	15.00	0	13,997,813			1.00
			0	13,997,813			
G - ATO RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,251,798	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
9.00		0.00	0	0		0	9.00
10.00		0.00	0	0		0	10.00
11.00		0.00	0	0		0	11.00
12.00		0.00	0	0		0	12.00
13.00		0.00	0	0		0	13.00
14.00		0.00	0	0		0	14.00
15.00		0.00	0	0		0	15.00
16.00		0.00	0	0		0	16.00
17.00		0.00	0	0		0	17.00
18.00		0.00	0	0		0	18.00
19.00		0.00	0	0		0	19.00
20.00		0.00	0	0		0	20.00
21.00		0.00	0	0		0	21.00
22.00		0.00	0	0		0	22.00
23.00		0.00	0	0		0	23.00
24.00		0.00	0	0		0	24.00
25.00		0.00	0	0		0	25.00

RECLASSIFICATIONS

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6

Date/Time Prepared:
11/20/2015 1:32 pm

Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.		
6.00	7.00	8.00	9.00	10.00			
26.00	0.00	0	0	0	0		26.00
27.00	0.00	0	0	0	0		27.00
28.00	0.00	0	0	0	0		28.00
29.00	0.00	0	0	0	0		29.00
30.00	0.00	0	0	0	0		30.00
31.00	0.00	0	0	0	0		31.00
32.00	0.00	0	0	0	0		32.00
33.00	0.00	0	0	0	0		33.00
0		1,251,798	0				
H - CENTEGRA ALLOCATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	15,888,012				1.00
			15,888,012	0			
I - CASE MANAGEMENT/SOCIAL SERVICES							
1.00	ADMINISTRATIVE & GENERAL	5.00	1,984,055	184,006	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
	TOTALS		1,984,055	184,006			
J - WORKERS COMP INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,194,794			1.00
			0	1,194,794			
K - SALARY RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	17,500	0	0		1.00
	0		17,500	0			
500.00	Grand Total: Decreases		22,649,142	43,684,917			500.00

RECLASSIFICATIONS

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
11/20/2015 1:32 pm

Increases				Decreases					
Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
A - CAPITAL RECLASS									
1.00	CAP REL COSTS-MVBLE EQUIP	2.00		6,251,327	CAP REL COSTS-BLDG & FI XT	1.00		6,288,323	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		36,996					2.00
			0	6,288,323			0	6,288,323	
B - CAFETERIA RECLASS									
1.00	CAFETERIA	11.00	780,420	703,132	DIETARY	10.00	780,420	703,132	1.00
			780,420	703,132			780,420	703,132	
C - MED SUPPLIES & IMPLANTS									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,853,181	ADMINISTRATIVE & GENERAL	5.00	0	4,871	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,886,484	HOUSEKEEPING	9.00	0	35	2.00
3.00		0.00	0	0	NURSING	13.00	0	167,831	3.00
4.00		0.00	0	0	ADMINISTRATION				
5.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	3,073	4.00
6.00		0.00	0	0	PHARMACY	15.00	0	28,333	5.00
7.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	170,148	6.00
8.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	89,401	7.00
9.00		0.00	0	0	SUBPROVIDER - I RF	41.00	0	29,254	8.00
10.00		0.00	0	0	OPERATING ROOM	50.00	0	10,017,116	9.00
11.00		0.00	0	0	RECOVERY ROOM	51.00	0	29,308	10.00
12.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	18,622	11.00
13.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	68,210	12.00
14.00		0.00	0	0	RADIOLOGY-THERAPEUTIC	55.00	0	5,207	13.00
15.00		0.00	0	0	CT SCAN	57.00	0	27,050	14.00
16.00		0.00	0	0	MRI	58.00	0	1,374	15.00
17.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	4,457,261	16.00
18.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	70,643	17.00
19.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	17,835	18.00
20.00		0.00	0	0	OCCUPATIONAL THERAPY	67.00	0	6,137	19.00
21.00		0.00	0	0	SPEECH PATHOLOGY	68.00	0	609	20.00
22.00		0.00	0	0	SLEEP LAB/NEUROLOGY	70.01	0	2,657	21.00
23.00		0.00	0	0	CARDIOLOGY	76.00	0	3,548	22.00
24.00		0.00	0	0	CARDIAC REHABILITATION	76.97	0	855	23.00
25.00		0.00	0	0	CLINIC	90.00	0	43,351	24.00
26.00		0.00	0	0	DIABETES CENTER	90.01	0	627	25.00
27.00		0.00	0	0	EMERGENCY	91.00	0	66,676	26.00
28.00		0.00	0	0	DURABLE MEDICAL EQUIP-SOLD	97.00	0	406,985	27.00
		0.00	0	0	FLIGHT FOR LIFE	192.02	0	2,648	28.00
0			0	15,739,665	0		0	15,739,665	
D - NURSERY									
1.00	NURSERY	43.00	941,047	530,248	ADULTS & PEDIATRICS	30.00	2,727,357	1,536,773	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,786,310	1,006,525					2.00
			2,727,357	1,536,773			2,727,357	1,536,773	
E - INTEREST EXPENSE									
1.00	CAP REL COSTS-BLDG & FI XT	1.00	0	4,040,071	ADMINISTRATIVE & GENERAL	5.00	0	356,238	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	340	INTEREST EXPENSE	113.00	0	3,684,173	2.00
	TOTALS		0	4,040,411	TOTALS		0	4,040,411	
F - CHARGABLE DRUG COSTS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	13,997,813	PHARMACY	15.00	0	13,997,813	1.00
			0	13,997,813			0	13,997,813	
G - ATO RECLASS									
1.00	ADMINISTRATIVE & GENERAL	5.00	75,557	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,251,798	0	1.00
2.00	OPERATION OF PLANT	7.00	20,680	0		0.00	0	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	895	0		0.00	0	0	3.00
4.00	HOUSEKEEPING	9.00	25,346	0		0.00	0	0	4.00
5.00	DIETARY	10.00	23,196	0		0.00	0	0	5.00
6.00	NURSING	13.00	15,743	0		0.00	0	0	6.00
7.00	ADMINISTRATION								
8.00	CENTRAL SERVICES & SUPPLY	14.00	8,369	0		0.00	0	0	7.00
9.00	PHARMACY	15.00	51,029	0		0.00	0	0	8.00
	ADULTS & PEDIATRICS	30.00	292,657	0		0.00	0	0	9.00

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
11/20/2015 1:32 pm

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
10.00	INTENSIVE CARE UNIT	31.00	66,292	0		0.00	0	0	10.00
11.00	SUBPROVIDER - IRF	41.00	42,543	0		0.00	0	0	11.00
12.00	OPERATING ROOM	50.00	135,289	0		0.00	0	0	12.00
13.00	RECOVERY ROOM	51.00	17,806	0		0.00	0	0	13.00
14.00	ANESTHESIOLOGY	53.00	1,098	0		0.00	0	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	83,279	0		0.00	0	0	15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	35,764	0		0.00	0	0	16.00
17.00	RADIOISOTOPE	56.00	11,788	0		0.00	0	0	17.00
18.00	CT SCAN	57.00	11,504	0		0.00	0	0	18.00
19.00	MRI	58.00	6,955	0		0.00	0	0	19.00
20.00	CARDIAC CATHETERIZATION	59.00	20,901	0		0.00	0	0	20.00
21.00	RESPIRATORY THERAPY	65.00	17,565	0		0.00	0	0	21.00
22.00	PHYSICAL THERAPY	66.00	99,762	0		0.00	0	0	22.00
23.00	OCCUPATIONAL THERAPY	67.00	17,517	0		0.00	0	0	23.00
24.00	SPEECH PATHOLOGY	68.00	7,564	0		0.00	0	0	24.00
25.00	SLEEP LAB/NEUROLOGY	70.01	1,564	0		0.00	0	0	25.00
26.00	CARDIOLOGY	76.00	9,586	0		0.00	0	0	26.00
27.00	CARDIAC REHABILITATION	76.97	12,436	0		0.00	0	0	27.00
28.00	CLINIC	90.00	9,266	0		0.00	0	0	28.00
29.00	DIABETES CENTER	90.01	1,370	0		0.00	0	0	29.00
30.00	EMERGENCY	91.00	62,502	0		0.00	0	0	30.00
31.00	DURABLE MEDICAL EQUIP-SOLD	97.00	6,642	0		0.00	0	0	31.00
32.00	HOME HEALTH AGENCY	101.00	59,124	0		0.00	0	0	32.00
33.00	OCCUPATIONAL HEALTH	192.01	209	0		0.00	0	0	33.00
0			1,251,798	0			1,251,798	0	0
H - CENTEGRA ALLOCATION									
1.00	ADMINISTRATIVE & GENERAL	5.00		15,888,012	ADMINISTRATIVE & GENERAL	5.00	15,888,012		1.00
			0	15,888,012			15,888,012	0	0
I - CASE MANAGEMENT/SOCIAL SERVICES									
1.00	ADULTS & PEDIATRICS	30.00	1,345,651	124,799	ADMINISTRATIVE & GENERAL	5.00	1,984,055	184,006	1.00
2.00	INTENSIVE CARE UNIT	31.00	193,700	17,964		0.00	0	0	2.00
3.00	SUBPROVIDER - IRF	41.00	289,365	26,836		0.00	0	0	3.00
4.00	NURSERY	43.00	155,339	14,407		0.00	0	0	4.00
	TOTALS		1,984,055	184,006	TOTALS		1,984,055	184,006	
J - WORKERS COMP INSURANCE									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		1,194,794	ADMINISTRATIVE & GENERAL	5.00		1,194,794	1.00
			0	1,194,794			0	1,194,794	
K - SALARY RECLASS									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,500	ADMINISTRATIVE & GENERAL	5.00	17,500	0	1.00
			0	17,500			17,500	0	
500.00	Grand Total: Increases		6,743,630	59,590,429	Grand Total: Decreases		22,649,142	43,684,917	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-7
Part I
Date/Time Prepared:
11/20/2015 1:32 pm

		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	65,000	0	0	0	0	1.00
2.00	Land Improvements	1,764,249	0	0	0	0	2.00
3.00	Buildings and Fixtures	81,429,870	1,909,624	0	1,909,624	0	3.00
4.00	Building Improvements	77,154	0	0	0	0	4.00
5.00	Fixed Equipment	12,588,902	0	0	0	0	5.00
6.00	Movable Equipment	96,388,985	6,288,082	0	6,288,082	0	6.00
7.00	HIT designated Assets	8,849,873	221,795	0	221,795	0	7.00
8.00	Subtotal (sum of lines 1-7)	201,164,033	8,419,501	0	8,419,501	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	201,164,033	8,419,501	0	8,419,501	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	65,000	0				1.00
2.00	Land Improvements	1,764,249	0				2.00
3.00	Buildings and Fixtures	83,339,494	0				3.00
4.00	Building Improvements	77,154	0				4.00
5.00	Fixed Equipment	12,588,902	0				5.00
6.00	Movable Equipment	102,677,067	0				6.00
7.00	HIT designated Assets	9,071,668	0				7.00
8.00	Subtotal (sum of lines 1-7)	209,583,534	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	209,583,534	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-7
Part II
Date/Time Prepared:
11/20/2015 1:32 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	9,515,883	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,515,883	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	9,515,883				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	9,515,883				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-7
Part III
Date/Time Prepared:
11/20/2015 1:32 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	85,245,897	0	85,245,897	0.406739	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	124,337,637	0	124,337,637	0.593261	0	2.00
3.00	Total (sum of lines 1-2)	209,583,534	0	209,583,534	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,227,560	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,251,327	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,478,887	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	356,026	0	0	0	3,583,586	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	340	0	0	0	6,251,667	2.00
3.00	Total (sum of lines 1-2)	356,366	0	0	0	9,835,253	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-2,896,765	CAP REL COSTS-BLDG & FIXT		1.00	11 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 2.00
3.00 Investment income - other (chapter 2)		0			0.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-141,794	OPERATION OF PLANT		7.00	0 7.00
8.00 Television and radio service (chapter 21)	A	-243,341	OPERATION OF PLANT		7.00	0 8.00
9.00 Parking lot (chapter 21)		0			0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-2,809,819				0 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	0 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-10,225,717				0 12.00
13.00 Laundry and linen service		0			0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-931,111	CAFETERIA		11.00	0 14.00
15.00 Rental of quarters to employee and others		0			0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0 16.00
17.00 Sale of drugs to other than patients		0			0.00	0 17.00
18.00 Sale of medical records and abstracts	B	-5,061	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 MEDICAL STAFF FEES	B	-53,688	ADMINISTRATIVE & GENERAL		5.00	0 33.00
34.00 OTHER INCOME	B	-267,607	ADMINISTRATIVE & GENERAL		5.00	0 34.00

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-8
Date/Time Prepared:
11/20/2015 1:32 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
35.00 RADIOLOGY X-RAY COPY FEES	B	-200	RADIOLOGY-DIAGNOSTIC		54.00	0 35.00
36.00 NURSING EDUCATION INCOME	B	-5,000	ADMINISTRATIVE & GENERAL		5.00	0 36.00
37.00 OB EDUCATION INCOME	B	-61,407	ADULTS & PEDIATRICS		30.00	0 37.00
38.00 RADIOLOGY OTHER INCOME	B	-47,880	RADIOLOGY-DIAGNOSTIC		54.00	0 38.00
39.00 EDUCATION INCOME	B	-4,838	EMERGENCY		91.00	0 39.00
40.00 EMS TUITION INCOME	B	-70,489	EMERGENCY		91.00	0 40.00
41.00 ONCOLOGY EDUCATION INCOME	B	-3,130	RADIOLOGY-THERAPEUTIC		55.00	0 41.00
42.00 PT OTHER INCOME	B	-70,550	PHYSICAL THERAPY		66.00	0 42.00
43.00 LABORATORY INCOME	B	-521,316	LABORATORY		60.00	0 43.00
44.00 MAINTENANCE SERVICES	B	-57,079	OPERATION OF PLANT		7.00	0 44.00
45.00 HOUSEKEEPING SERVICES	B	-186,147	HOUSEKEEPING		9.00	0 45.00
45.01 PHARMACY OTHER INCOME	B	-810	PHARMACY		15.00	0 45.01
45.02 PHARMACY RETAIL INCOME	B	-581,957	PHARMACY		15.00	0 45.02
45.03 RELATED PARTY SALARIES	A	-17,500	ADMINISTRATIVE & GENERAL		5.00	0 45.03
45.04 RELATED PARTY BENEFITS	A	-3,382	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 45.04
45.05 MEALS ON WHEELS	B	-20,487	CAFETERIA		11.00	0 45.05
45.06 IDPA PROVIDER TAX	A	-7,589,544	ADMINISTRATIVE & GENERAL		5.00	0 45.06
45.07 CHILD CARE CENTER	B	-786,866	ADMINISTRATIVE & GENERAL		5.00	0 45.07
45.08 2012 & 2014 INTEREST INCOME	B	-185	CAP REL COSTS-BLDG & FIXT		1.00	11 45.08
45.09 2012 & 2014 INTEREST EXPENSE	A	-787,095	CAP REL COSTS-BLDG & FIXT		1.00	11 45.09
45.10 RELATED RENTAL - POM/BIOMED	A	-32,213	OPERATION OF PLANT		7.00	0 45.10
45.11 RELATED RENTAL - NURSING ADMIN	A	-12,587	NURSING ADMINISTRATION		13.00	0 45.11
45.12 RELATED RENTAL - MEDICAL RECORDS	A	-8,233	MEDICAL RECORDS & LIBRARY		16.00	0 45.12
45.13 RELATED RENTAL - RADIOLOGY	A	-91,815	RADIOLOGY-DIAGNOSTIC		54.00	0 45.13
45.14 RELATED RENTAL - ONCOLOGY ADMIN	A	-20,030	RADIOLOGY-THERAPEUTIC		55.00	0 45.14
45.15 RELATED RENTAL - PHYSICAL THERAPY	A	-202,898	PHYSICAL THERAPY		66.00	0 45.15
45.16 RELATED RENTAL - OCCUPATIONAL THERAP	A	-40,023	OCCUPATIONAL THERAPY		67.00	0 45.16
45.17 RELATED RENTAL - CARDIAC REHAB	A	-112,640	CARDIAC REHABILITATION		76.97	0 45.17
45.18 RELATED RENTAL - VARIOUS CLINICS	A	-467,930	CLINIC		90.00	0 45.18
45.19 RELATED RENTAL - DIABETES CENTER	A	-3,744	DIABETES CENTER		90.01	0 45.19
45.20 RELATED RENTAL - ER	A	-10,746	EMERGENCY		91.00	0 45.20
45.21 RELATED RENTAL - DME	A	-1,362	DURABLE MEDICAL EQUIP-SOLD		97.00	0 45.21
45.22 RELATED RENTAL - HOME HEALTH	A	-51,869	HOME HEALTH AGENCY		101.00	0 45.22
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-29,446,855				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: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-8-1

Date/Time Prepared:
11/20/2015 1:32 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	CENTEGRA HEALTH SYSTEM	34,986,570	46,157,758 1.00
2.00	13.00	NURSING ADMINISTRATION	CENTEGRA HEALTH SYSTEM	411,834	0 2.00
3.00	91.00	EMERGENCY	CENTEGRA HEALTH SYSTEM	464,805	0 3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	CENTEGRA INSURANCE SERVICES	1,678,853	1,610,021 4.00
5.00	0		0	37,542,062	47,767,779 5.00

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

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

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

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

6.00	B	0.00	CENTEGRA HEALTH	0.00	6.00
7.00	B	0.00	CENTEGRA INSURA	0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-8-1

Date/Time Prepared:
11/20/2015 1:32 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-11,171,188	0		1.00
2.00	411,834	0		2.00
3.00	464,805	0		3.00
4.00	68,832	0		4.00
5.00	-10,225,717			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	HOME OFFICE		6.00
7.00	INSURANCE SERVI		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: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-8-2

Date/Time Prepared:
11/20/2015 1:32 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,514,475	1,514,475	0	0	0	1.00
2.00	30.00	DR. BA	86,250	0	86,250	208,000	219	2.00
3.00	30.00	DR. BB	86,250	0	86,250	208,000	116	3.00
4.00	50.00	OPERATING ROOM	277,294	277,294	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	60,000	0	60,000	200,300	378	5.00
6.00	54.00	DR. BC	156,000	0	156,000	225,300	552	6.00
7.00	54.00	DR. BD	24,000	0	24,000	225,300	121	7.00
8.00	54.00	DR. BE	24,000	0	24,000	225,300	150	8.00
9.00	54.00	DR. BF	3,100	0	3,100	225,300	4	9.00
10.00	54.00	DR. BG	6,000	0	6,000	225,300	138	10.00
11.00	65.00	RESPIRATORY THERAPY	53,371	50,927	2,444	177,200	89	11.00
12.00	66.00	PHYSICAL THERAPY	19,500	0	19,500	177,200	36	12.00
13.00	76.97	DR. BH	3,500	0	3,500	177,200	6	13.00
14.00	76.97	DR. BI	4,550	0	4,550	177,200	33	14.00
15.00	55.00	RADIOLOGY-THERAPEUTIC	39,996	0	39,996	177,200	254	15.00
16.00	90.00	CLINIC	6,663	6,663	0	0	0	16.00
17.00	90.00	CLINIC	29,640	0	29,640	177,200	136	17.00
18.00	90.01	DIABETES CENTER	5,000	0	5,000	177,200	36	18.00
19.00	91.00	EMERGENCY	455,600	425,600	30,000	177,200	21	19.00
20.00	5.00	ADMINISTRATIVE & GENERAL	157,627	157,627	0	0	0	20.00
21.00	5.00	DR. BJ	6,338	0	6,338	177,200	19	21.00
22.00	5.00	DR. BK	13,026	0	13,026	177,200	98	22.00
23.00	5.00	DR. BL	15,600	0	15,600	177,200	269	23.00
200.00			3,047,780	2,432,586	615,194		2,675	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	30.00	DR. BA	21,900	1,095	0	0	0	2.00
3.00	30.00	DR. BB	11,600	580	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	36,401	1,820	0	0	0	5.00
6.00	54.00	DR. BC	59,791	2,990	0	0	0	6.00
7.00	54.00	DR. BD	13,106	655	0	0	0	7.00
8.00	54.00	DR. BE	16,248	812	0	0	0	8.00
9.00	54.00	DR. BF	433	22	0	0	0	9.00
10.00	54.00	DR. BG	14,948	747	0	0	0	10.00
11.00	65.00	RESPIRATORY THERAPY	7,582	379	0	0	0	11.00
12.00	66.00	PHYSICAL THERAPY	3,067	153	0	0	0	12.00
13.00	76.97	DR. BH	511	26	0	0	0	13.00
14.00	76.97	DR. BI	2,811	141	0	0	0	14.00
15.00	55.00	RADIOLOGY-THERAPEUTIC	21,639	1,082	0	0	0	15.00
16.00	90.00	CLINIC	0	0	0	0	0	16.00
17.00	90.00	CLINIC	11,586	579	0	0	0	17.00
18.00	90.01	DIABETES CENTER	3,067	153	0	0	0	18.00
19.00	91.00	EMERGENCY	1,789	89	0	0	0	19.00
20.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	20.00
21.00	5.00	DR. BJ	1,619	81	0	0	0	21.00
22.00	5.00	DR. BK	8,349	417	0	0	0	22.00
23.00	5.00	DR. BL	22,917	1,146	0	0	0	23.00
200.00			259,364	12,967	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,514,475		1.00
2.00	30.00	DR. BA	0	21,900	64,350	64,350		2.00
3.00	30.00	DR. BB	0	11,600	74,650	74,650		3.00
4.00	50.00	OPERATING ROOM	0	0	0	277,294		4.00
5.00	53.00	ANESTHESIOLOGY	0	36,401	23,599	23,599		5.00
6.00	54.00	DR. BC	0	59,791	96,209	96,209		6.00
7.00	54.00	DR. BD	0	13,106	10,894	10,894		7.00
8.00	54.00	DR. BE	0	16,248	7,752	7,752		8.00
9.00	54.00	DR. BF	0	433	2,667	2,667		9.00
10.00	54.00	DR. BG	0	14,948	0	0		10.00
11.00	65.00	RESPIRATORY THERAPY	0	7,582	0	50,927		11.00
12.00	66.00	PHYSICAL THERAPY	0	3,067	16,433	16,433		12.00
13.00	76.97	DR. BH	0	511	2,989	2,989		13.00
14.00	76.97	DR. BI	0	2,811	1,739	1,739		14.00
15.00	55.00	RADIOLOGY-THERAPEUTIC	0	21,639	18,357	18,357		15.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-8-2

Date/Time Prepared:
11/20/2015 1:32 pm

	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		
16.00	90.00	CLINIC	0	0	0	6,663		16.00
17.00	90.00	CLINIC	0	11,586	18,054	18,054		17.00
18.00	90.01	DIABETES CENTER	0	3,067	1,933	1,933		18.00
19.00	91.00	EMERGENCY	0	1,789	28,211	453,811		19.00
20.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	157,627		20.00
21.00	5.00	DR. BJ	0	1,619	4,719	4,719		21.00
22.00	5.00	DR. BK	0	8,349	4,677	4,677		22.00
23.00	5.00	DR. BL	0	22,917	0	0		23.00
200.00			0	259,364	377,233	2,809,819		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part I
Date/Time Prepared:
11/20/2015 1:32 pm

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	3,583,586	3,583,586			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	6,251,667		6,251,667		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	18,929,100	3,262	5,691	18,938,053	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	39,468,755	668,232	1,165,748	661,877	5.00
7.00 00700	OPERATION OF PLANT	3,645,025	294,292	513,401	375,902	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	841,471	5,783	10,088	11,299	8.00
9.00 00900	HOUSEKEEPING	2,171,336	41,468	72,342	390,069	9.00
10.00 01000	DIETARY	2,001,478	106,644	186,043	202,746	10.00
11.00 01100	CAFETERIA	531,954	0	0	198,917	11.00
13.00 01300	NURSING ADMINISTRATION	2,371,989	20,104	35,072	473,982	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,685,642	69,183	120,692	117,977	14.00
15.00 01500	PHARMACY	3,794,012	52,332	91,295	879,465	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,189,122	6,691	11,673	112	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	17,106,444	595,648	1,039,125	4,238,653	30.00
31.00 03100	INTENSIVE CARE UNIT	4,873,905	111,096	193,811	1,061,504	31.00
41.00 04100	SUBPROVIDER - IIRF	2,824,952	112,530	196,311	680,868	41.00
43.00 04300	NURSERY	1,641,041	94,390	164,667	279,452	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	10,880,565	513,895	896,504	1,827,595	50.00
51.00 05100	RECOVERY ROOM	1,168,793	28,889	50,398	274,054	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,792,835	51,749	90,277	455,304	52.00
53.00 05300	ANESTHESIOLOGY	469,733	8,081	14,098	10,721	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	7,118,458	178,790	311,904	1,208,488	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	2,606,922	139,788	243,864	484,889	55.00
56.00 05600	RADIOISOTOPE	1,463,016	34,838	60,776	145,649	56.00
57.00 05700	CT SCAN	980,883	23,309	40,664	181,062	57.00
58.00 05800	MRI	421,325	26,233	45,764	74,126	58.00
59.00 05900	CARDIAC CATHETERIZATION	2,063,229	130,422	227,524	322,692	59.00
60.00 06000	LABORATORY	5,144,875	13,645	23,803	674	60.00
65.00 06500	RESPIRATORY THERAPY	1,573,593	16,088	28,066	321,239	65.00
66.00 06600	PHYSICAL THERAPY	6,183,285	58,063	101,292	1,354,360	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,118,967	0	0	276,363	67.00
68.00 06800	SPEECH PATHOLOGY	456,515	0	0	114,646	68.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01 07001	SLEEP LAB/NEUROLOGY	208,435	2,755	4,807	31,592	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,853,181	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	9,886,484	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	13,997,813	0	0	0	73.00
76.00 03140	CARDIOLOGY	459,377	18,300	31,925	108,266	76.00
76.97 07697	CARDIAC REHABILITATION	628,292	0	0	134,315	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	5,477,350	22,204	38,736	105,532	90.00
90.01 09001	DIABETES CENTER	136,851	0	0	25,967	90.01
91.00 09100	EMERGENCY	5,507,895	116,854	203,856	1,070,154	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	800,216	0	0	86,943	97.00
101.00 10100	HOME HEALTH AGENCY	3,335,221	0	0	750,035	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	205,645,588	3,565,558	6,220,217	18,937,489	205,595,546
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,028	31,450	0	49,478
192.01 19201	OCCUPATIONAL HEALTH	6,532	0	0	564	7,096
192.02 19202	FLIGHT FOR LIFE	5,414	0	0	0	5,414
192.04 19204	WELLNESS PROGRAM	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	205,657,534	3,583,586	6,251,667	18,938,053	205,657,534

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140116

Period: 07/01/2014 To 06/30/2015

Worksheet B Part I Date/Time Prepared: 11/20/2015 1:32 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	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	41,964,612				5.00
7.00	00700	OPERATION OF PLANT	1,237,875	6,066,495			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	222,687	13,401	1,104,729		8.00
9.00	00900	HOUSEKEEPING	685,823	96,098	0	3,457,136	9.00
10.00	01000	DIETARY	640,113	247,137	0	143,426	3,527,587
11.00	01100	CAFETERIA	187,368	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	743,744	46,589	0	27,038	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	511,056	160,326	0	93,045	14.00
15.00	01500	PHARMACY	1,234,922	121,275	0	70,382	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	822,306	15,506	0	8,999	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,891,136	1,380,353	401,887	801,086	2,595,756
31.00	03100	INTENSIVE CARE UNIT	1,599,780	257,455	95,503	149,414	373,644
41.00	04100	SUBPROVIDER - IRF	977,934	260,776	17,768	151,341	558,187
43.00	04300	NURSERY	558,754	218,741	4,255	126,946	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,619,462	1,190,901	116,381	691,138	0
51.00	05100	RECOVERY ROOM	390,217	66,948	21,099	38,853	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	869,109	119,922	8,077	69,597	0
53.00	05300	ANESTHESIOLOGY	128,856	18,727	0	10,868	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,260,508	414,328	35,536	240,455	0
55.00	05500	RADIOLOGY-THERAPEUTIC	890,977	323,945	0	188,001	0
56.00	05600	RADIOISOTOPE	436,912	80,733	0	46,853	0
57.00	05700	CT SCAN	314,279	54,017	0	31,349	0
58.00	05800	MRI	145,472	60,792	0	35,280	0
59.00	05900	CARDIAC CATHETERIZATION	703,423	302,240	77,735	175,404	0
60.00	06000	LABORATORY	1,328,723	31,620	0	18,351	0
65.00	06500	RESPIRATORY THERAPY	497,082	37,282	0	21,637	0
66.00	06600	PHYSICAL THERAPY	1,973,218	134,555	0	78,089	0
67.00	06700	OCCUPATIONAL THERAPY	357,710	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	146,424	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
70.01	07001	SLEEP LAB/NEUROLOGY	63,472	6,386	0	3,706	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,500,533	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,534,519	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,588,507	0	0	0	0
76.00	03140	CARDIOLOGY	158,398	42,408	0	24,611	0
76.97	07697	CARDIAC REHABILITATION	195,503	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,446,861	51,457	0	29,863	0
90.01	09001	DIABETES CENTER	41,740	0	0	0	0
91.00	09100	EMERGENCY	1,768,580	270,799	326,488	157,158	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	227,434	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	1,047,304	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,948,721	6,024,717	1,104,729	3,432,890	3,527,587
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,684	41,778	0	24,246	0
192.01	19201	OCCUPATIONAL HEALTH	1,819	0	0	0	0
192.02	19202	FLIGHT FOR LIFE	1,388	0	0	0	0
192.04	19204	WELLNESS PROGRAM	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	41,964,612	6,066,495	1,104,729	3,457,136	3,527,587

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part I
Date/Time Prepared:
11/20/2015 1:32 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	918,239					11.00
13.00	01300	20,876	3,739,394				13.00
14.00	01400	11,141	0	2,769,062			14.00
15.00	01500	39,019	0	0	6,282,702		15.00
16.00	01600	0	0	0	0	4,054,409	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	263,396	1,853,068	0	0	347,883	30.00
31.00	03100	55,007	386,960	0	0	74,366	31.00
41.00	04100	38,604	271,610	0	0	48,158	41.00
43.00	04300	14,035	98,761	0	0	21,737	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	93,307	656,400	0	0	484,552	50.00
51.00	05100	11,526	81,063	0	0	58,573	51.00
52.00	05200	22,707	159,771	0	0	41,262	52.00
53.00	05300	1,002	7,081	0	0	60,148	53.00
54.00	05400	61,099	0	0	0	402,482	54.00
55.00	05500	21,503	0	0	0	155,934	55.00
56.00	05600	6,294	0	0	0	83,135	56.00
57.00	05700	8,692	0	0	0	299,730	57.00
58.00	05800	3,643	0	0	0	68,431	58.00
59.00	05900	15,118	0	0	0	137,658	59.00
60.00	06000	51	0	0	0	325,845	60.00
65.00	06500	19,570	137,689	0	0	52,172	65.00
66.00	06600	67,200	0	0	0	165,747	66.00
67.00	06700	13,236	0	0	0	30,326	67.00
68.00	06800	5,232	0	0	0	17,506	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	2,297	0	0	0	9,283	70.01
71.00	07100	0	0	1,029,744	0	104,116	71.00
72.00	07200	0	0	1,739,318	0	193,495	72.00
73.00	07300	0	0	0	6,282,702	437,125	73.00
76.00	03140	5,565	39,188	0	0	21,896	76.00
76.97	07697	6,790	47,803	0	0	10,908	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	5,292	0	0	0	62,287	90.00
90.01	09001	1,558	0	0	0	2,112	90.01
91.00	09100	57,790	0	0	0	284,378	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	5,474	0	0	0	17,518	97.00
101.00	10100	41,144	0	0	0	35,646	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		918,168	3,739,394	2,769,062	6,282,702	4,054,409	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.01	19201	71	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.04	19204	0	0	0	0	0	192.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		918,239	3,739,394	2,769,062	6,282,702	4,054,409	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part I
Date/Time Prepared:
11/20/2015 1:32 pm

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		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
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	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	36,514,435	0	36,514,435
31.00	03100	INTENSIVE CARE UNIT	0	9,232,445	0	9,232,445
41.00	04100	SUBPROVIDER - I RF	0	6,139,039	0	6,139,039
43.00	04300	NURSERY	0	3,222,779	0	3,222,779
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	20,970,700	0	20,970,700
51.00	05100	RECOVERY ROOM	0	2,190,413	0	2,190,413
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,680,610	0	4,680,610
53.00	05300	ANESTHESIOLOGY	0	729,315	0	729,315
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,232,048	0	12,232,048
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,055,823	0	5,055,823
56.00	05600	RADIOISOTOPE	0	2,358,206	0	2,358,206
57.00	05700	CT SCAN	0	1,933,985	0	1,933,985
58.00	05800	MRI	0	881,066	0	881,066
59.00	05900	CARDIAC CATHETERIZATION	0	4,155,445	0	4,155,445
60.00	06000	LABORATORY	0	6,887,587	0	6,887,587
65.00	06500	RESPIRATORY THERAPY	0	2,704,418	0	2,704,418
66.00	06600	PHYSICAL THERAPY	0	10,115,809	0	10,115,809
67.00	06700	OCCUPATIONAL THERAPY	0	1,796,602	0	1,796,602
68.00	06800	SPEECH PATHOLOGY	0	740,323	0	740,323
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0
70.01	07001	SLEEP LAB/NEUROLOGY	0	332,733	0	332,733
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,487,574	0	8,487,574
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,353,816	0	14,353,816
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,306,147	0	24,306,147
76.00	03140	CARDIOLOGY	0	909,934	0	909,934
76.97	07697	CARDIAC REHABILITATION	0	1,023,611	0	1,023,611
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,239,582	0	7,239,582
90.01	09001	DIABETES CENTER	0	208,228	0	208,228
91.00	09100	EMERGENCY	0	9,763,952	0	9,763,952
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	
OTHER REIMBURSABLE COST CENTERS						
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	1,137,585	0	1,137,585
101.00	10100	HOME HEALTH AGENCY	0	5,209,350	0	5,209,350
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	205,513,560	0	205,513,560
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	128,186	0	128,186
192.01	19201	OCCUPATIONAL HEALTH	0	8,986	0	8,986
192.02	19202	FLIGHT FOR LIFE	0	6,802	0	6,802
192.04	19204	WELLNESS PROGRAM	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	0	205,657,534	0	205,657,534

Provider CCN: 140116

Period:
 From 07/01/2014
 To 06/30/2015

Worksheet Non-CMS W
 Date/Time Prepared:
 11/20/2015 1:32 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	2	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	3	MEALS SERVED	10.00
11.00	CAFETERIA	4	FTES	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NRSING	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	16.00
17.00	SOCIAL SERVICE	17	TIME SPENT	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part II
Date/Time Prepared:
11/20/2015 1:32 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,262	5,691	8,953	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,372,025	668,232	1,165,748	3,206,005	5.00
7.00 00700	OPERATION OF PLANT	81,683	294,292	513,401	889,376	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	5,783	10,088	15,871	8.00
9.00 00900	HOUSEKEEPING	0	41,468	72,342	113,810	9.00
10.00 01000	DIETARY	13,799	106,644	186,043	306,486	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	19,158	20,104	35,072	74,334	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	229,044	69,183	120,692	418,919	14.00
15.00 01500	PHARMACY	645,446	52,332	91,295	789,073	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	13,271	6,691	11,673	31,635	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	17,403	595,648	1,039,125	1,652,176	30.00
31.00 03100	INTENSIVE CARE UNIT	-714	111,096	193,811	304,193	31.00
41.00 04100	SUBPROVIDER - IRF	0	112,530	196,311	308,841	41.00
43.00 04300	NURSERY	0	94,390	164,667	259,057	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	210,847	513,895	896,504	1,621,246	50.00
51.00 05100	RECOVERY ROOM	1,909	28,889	50,398	81,196	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	51,749	90,277	142,026	52.00
53.00 05300	ANESTHESIOLOGY	9,440	8,081	14,098	31,619	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	728,844	178,790	311,904	1,219,538	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	40,221	139,788	243,864	423,873	55.00
56.00 05600	RADIO SOTOPE	0	34,838	60,776	95,614	56.00
57.00 05700	CT SCAN	0	23,309	40,664	63,973	57.00
58.00 05800	MRI	0	26,233	45,764	71,997	58.00
59.00 05900	CARDIAC CATHETERIZATION	784	130,422	227,524	358,730	59.00
60.00 06000	LABORATORY	0	13,645	23,803	37,448	60.00
65.00 06500	RESPIRATORY THERAPY	40,768	16,088	28,066	84,922	65.00
66.00 06600	PHYSICAL THERAPY	840,461	58,063	101,292	999,816	66.00
67.00 06700	OCCUPATIONAL THERAPY	68,027	0	0	68,027	67.00
68.00 06800	SPEECH PATHOLOGY	1,173	0	0	1,173	68.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01 07001	SLEEP LAB/NEUROLOGY	53,357	2,755	4,807	60,919	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03140	CARDIOLOGY	396	18,300	31,925	50,621	76.00
76.97 07697	CARDIAC REHABILITATION	185,860	0	0	185,860	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	865,430	22,204	38,736	926,370	90.00
90.01 09001	DIABETES CENTER	31,940	0	0	31,940	90.01
91.00 09100	EMERGENCY	17,275	116,854	203,856	337,985	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS						
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	1,926	0	0	1,926	97.00
101.00 10100	HOME HEALTH AGENCY	74,808	0	0	74,808	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,564,581	3,565,558	6,220,217	15,350,356	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,028	31,450	49,478	190.00
192.01 19201	OCCUPATIONAL HEALTH	0	0	0	0	192.01
192.02 19202	FLIGHT FOR LIFE	0	0	0	0	192.02
192.04 19204	WELLNESS PROGRAM	0	0	0	0	192.04
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	5,564,581	3,583,586	6,251,667	15,399,834	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet B Part II Date/Time Prepared: 11/20/2015 1:32 pm		
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5.00	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	3,206,317			5.00
7.00	00700	OPERATION OF PLANT	94,578	984,131		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,014	2,174	35,064	8.00
9.00	00900	HOUSEKEEPING	52,399	15,589	0	181,982
10.00	01000	DIETARY	48,907	40,091	0	7,550
11.00	01100	CAFETERIA	14,316	0	0	0
13.00	01300	NURSING ADMINISTRATION	56,825	7,558	0	1,423
14.00	01400	CENTRAL SERVICES & SUPPLY	39,047	26,009	0	4,898
15.00	01500	PHARMACY	94,353	19,674	0	3,705
16.00	01600	MEDICAL RECORDS & LIBRARY	62,827	2,515	0	474
17.00	01700	SOCIAL SERVICE	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	450,170	223,927	12,756	42,169
31.00	03100	INTENSIVE CARE UNIT	122,229	41,765	3,031	7,865
41.00	04100	SUBPROVIDER - I RF	74,718	42,304	564	7,967
43.00	04300	NURSERY	42,691	35,485	135	6,682
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	276,540	193,193	3,694	36,381
51.00	05100	RECOVERY ROOM	29,814	10,861	670	2,045
52.00	05200	DELIVERY ROOM & LABOR ROOM	66,403	19,454	256	3,664
53.00	05300	ANESTHESIOLOGY	9,845	3,038	0	572
54.00	05400	RADIOLOGY-DIAGNOSTIC	172,711	67,214	1,128	12,657
55.00	05500	RADIOLOGY-THERAPEUTIC	68,074	52,552	0	9,896
56.00	05600	RADIOISOTOPE	33,382	13,097	0	2,466
57.00	05700	CT SCAN	24,012	8,763	0	1,650
58.00	05800	MRI	11,115	9,862	0	1,857
59.00	05900	CARDIAC CATHETERIZATION	53,744	49,030	2,467	9,233
60.00	06000	LABORATORY	101,519	5,130	0	966
65.00	06500	RESPIRATORY THERAPY	37,979	6,048	0	1,139
66.00	06600	PHYSICAL THERAPY	150,761	21,828	0	4,111
67.00	06700	OCCUPATIONAL THERAPY	27,330	0	0	0
68.00	06800	SPEECH PATHOLOGY	11,187	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0
70.01	07001	SLEEP LAB/NEUROLOGY	4,850	1,036	0	195
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	114,646	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	193,647	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	274,175	0	0	0
76.00	03140	CARDIOLOGY	12,102	6,880	0	1,296
76.97	07697	CARDIAC REHABILITATION	14,937	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	110,546	8,347	0	1,572
90.01	09001	DIABETES CENTER	3,189	0	0	0
91.00	09100	EMERGENCY	135,126	43,930	10,363	8,273
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				
OTHER REIMBURSABLE COST CENTERS						
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	17,377	0	0	0
101.00	10100	HOME HEALTH AGENCY	80,018	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,205,103	977,354	35,064	180,706
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	969	6,777	0	1,276
192.01	19201	OCCUPATIONAL HEALTH	139	0	0	0
192.02	19202	FLIGHT FOR LIFE	106	0	0	0
192.04	19204	WELLNESS PROGRAM	0	0	0	0
200.00		Cross Foot Adjustments				
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,206,317	984,131	35,064	181,982

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140116		Period: From 07/01/2014 To 06/30/2015		Worksheet B Part II Date/Time Prepared: 11/20/2015 1:32 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	14,410					11.00
13.00	01300		140,691				13.00
14.00	01400	175	0	489,104			14.00
15.00	01500	612	0	0	907,831		15.00
16.00	01600	0	0	0	0	97,451	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,134	69,721	0	0	8,351	30.00
31.00	03100	863	14,559	0	0	1,785	31.00
41.00	04100	606	10,219	0	0	1,156	41.00
43.00	04300	220	3,716	0	0	522	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,464	24,696	0	0	11,757	50.00
51.00	05100	181	3,050	0	0	1,406	51.00
52.00	05200	356	6,011	0	0	990	52.00
53.00	05300	16	266	0	0	1,444	53.00
54.00	05400	959	0	0	0	9,661	54.00
55.00	05500	337	0	0	0	3,743	55.00
56.00	05600	99	0	0	0	1,996	56.00
57.00	05700	136	0	0	0	7,195	57.00
58.00	05800	57	0	0	0	1,643	58.00
59.00	05900	237	0	0	0	3,304	59.00
60.00	06000	1	0	0	0	7,822	60.00
65.00	06500	307	5,180	0	0	1,252	65.00
66.00	06600	1,055	0	0	0	3,979	66.00
67.00	06700	208	0	0	0	728	67.00
68.00	06800	82	0	0	0	420	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	36	0	0	0	223	70.01
71.00	07100	0	0	181,888	0	2,499	71.00
72.00	07200	0	0	307,216	0	4,645	72.00
73.00	07300	0	0	0	907,831	10,493	73.00
76.00	03140	87	1,474	0	0	526	76.00
76.97	07697	107	1,799	0	0	262	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	83	0	0	0	1,495	90.00
90.01	09001	24	0	0	0	51	90.01
91.00	09100	907	0	0	0	6,826	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	86	0	0	0	421	97.00
101.00	10100	646	0	0	0	856	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		14,409	140,691	489,104	907,831	97,451	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.01	19201	1	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.04	19204	0	0	0	0	0	192.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		14,410	140,691	489,104	907,831	97,451	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140116		Period: From 07/01/2014 To 06/30/2015		Worksheet B Part II Date/Time Prepared: 11/20/2015 1:32 pm	
Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
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	0					17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,762,076	0	2,762,076		30.00
31.00	03100	INTENSIVE CARE UNIT	0	539,490	0	539,490		31.00
41.00	04100	SUBPROVIDER - IRF	0	510,485	0	510,485		41.00
43.00	04300	NURSERY	0	348,640	0	348,640		43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,169,831	0	2,169,831		50.00
51.00	05100	RECOVERY ROOM	0	129,352	0	129,352		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	239,374	0	239,374		52.00
53.00	05300	ANESTHESIOLOGY	0	46,805	0	46,805		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,484,437	0	1,484,437		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	558,703	0	558,703		55.00
56.00	05600	RADIOISOTOPE	0	146,723	0	146,723		56.00
57.00	05700	CT SCAN	0	105,814	0	105,814		57.00
58.00	05800	MRI	0	96,566	0	96,566		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	476,897	0	476,897		59.00
60.00	06000	LABORATORY	0	152,886	0	152,886		60.00
65.00	06500	RESPIRATORY THERAPY	0	136,978	0	136,978		65.00
66.00	06600	PHYSICAL THERAPY	0	1,182,188	0	1,182,188		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	96,423	0	96,423		67.00
68.00	06800	SPEECH PATHOLOGY	0	12,916	0	12,916		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	67,274	0	67,274		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	299,033	0	299,033		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	505,508	0	505,508		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,192,499	0	1,192,499		73.00
76.00	03140	CARDIOLOGY	0	73,037	0	73,037		76.00
76.97	07697	CARDIAC REHABILITATION	0	203,028	0	203,028		76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,048,463	0	1,048,463		90.00
90.01	09001	DIABETES CENTER	0	35,216	0	35,216		90.01
91.00	09100	EMERGENCY	0	543,914	0	543,914		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0			92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	19,851	0	19,851		97.00
101.00	10100	HOME HEALTH AGENCY	0	156,681	0	156,681		101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	15,341,088	0	15,341,088		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	58,500	0	58,500		190.00
192.01	19201	OCCUPATIONAL HEALTH	0	140	0	140		192.01
192.02	19202	FLIGHT FOR LIFE	0	106	0	106		192.02
192.04	19204	WELLNESS PROGRAM	0	0	0	0		192.04
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	15,399,834	0	15,399,834		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1
Date/Time Prepared:
11/20/2015 1:32 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,480,227					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		3,480,227				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,168	3,168	74,300,252			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	648,959	648,959	2,596,768	-41,964,612	163,692,922	5.00
7.00 00700	OPERATION OF PLANT	285,804	285,804	1,474,792	0	4,828,620	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	5,616	5,616	44,328	0	868,641	8.00
9.00 00900	HOUSEKEEPING	40,272	40,272	1,530,374	0	2,675,215	9.00
10.00 01000	DIETARY	103,568	103,568	795,442	0	2,496,911	10.00
11.00 01100	CAFETERIA	0	0	780,420	0	730,871	11.00
13.00 01300	NURSING ADMINISTRATION	19,524	19,524	1,859,590	0	2,901,147	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	67,188	67,188	462,863	0	1,993,494	14.00
15.00 01500	PHARMACY	50,823	50,823	3,450,440	0	4,817,104	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	6,498	6,498	440	0	3,207,598	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	578,468	578,468	16,629,529	0	22,979,870	30.00
31.00 03100	INTENSIVE CARE UNIT	107,892	107,892	4,164,639	0	6,240,316	31.00
41.00 04100	SUBPROVIDER - IRF	109,284	109,284	2,671,276	0	3,814,661	41.00
43.00 04300	NURSERY	91,668	91,668	1,096,386	0	2,179,550	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	499,073	499,073	7,170,274	0	14,118,559	50.00
51.00 05100	RECOVERY ROOM	28,056	28,056	1,075,206	0	1,522,134	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	50,256	50,256	1,786,310	0	3,390,165	52.00
53.00 05300	ANESTHESIOLOGY	7,848	7,848	42,062	0	502,633	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	173,633	173,633	4,741,308	0	8,817,640	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	135,756	135,756	1,902,384	0	3,475,463	55.00
56.00 05600	RADIOISOTOPE	33,833	33,833	571,430	0	1,704,279	56.00
57.00 05700	CT SCAN	22,637	22,637	710,369	0	1,225,918	57.00
58.00 05800	MRI	25,476	25,476	290,822	0	567,448	58.00
59.00 05900	CARDIAC CATHETERIZATION	126,660	126,660	1,266,028	0	2,743,867	59.00
60.00 06000	LABORATORY	13,251	13,251	2,644	0	5,182,997	60.00
65.00 06500	RESPIRATORY THERAPY	15,624	15,624	1,260,329	0	1,938,986	65.00
66.00 06600	PHYSICAL THERAPY	56,388	56,388	5,313,612	0	7,697,000	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	1,084,266	0	1,395,330	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	449,796	0	571,161	68.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01 07001	SLEEP LAB/NEUROLOGY	2,676	2,676	123,947	0	247,589	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	5,853,181	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,886,484	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	13,997,813	73.00
76.00 03140	CARDIOLOGY	17,772	17,772	424,766	0	617,868	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	526,964	0	762,607	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	21,564	21,564	414,039	0	5,643,822	90.00
90.01 09001	DIABETES CENTER	0	0	101,876	0	162,818	90.01
91.00 09100	EMERGENCY	113,484	113,484	4,198,574	0	6,898,759	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS							
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	341,106	0	887,159	97.00
101.00 10100	HOME HEALTH AGENCY	0	0	2,942,642	0	4,085,256	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,462,719	3,462,719	74,298,041	-41,964,612	163,630,934	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,508	17,508	0	0	49,478	190.00
192.01 19201	OCCUPATIONAL HEALTH	0	0	2,211	0	7,096	192.01
192.02 19202	FLIGHT FOR LIFE	0	0	0	0	5,414	192.02
192.04 19204	WELLNESS PROGRAM	0	0	0	0	0	192.04
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)	3,583,586	6,251,667	18,938,053		41,964,612	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.029699	1.796339	0.254885		0.256362	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			8,953		3,206,317	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000120		0.019587	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1

Date/Time Prepared:
11/20/2015 1:32 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	2,542,296				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	5,616	1,283,731			8.00	
9.00	00900	HOUSEKEEPING	40,272	0	2,496,408		9.00	
10.00	01000	DIETARY	103,568	0	103,568	325,725	10.00	
11.00	01100	CAFETERIA	0	0	0	90,744	11.00	
13.00	01300	NURSING ADMINISTRATION	19,524	0	19,524	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	67,188	0	67,188	0	14.00	
15.00	01500	PHARMACY	50,823	0	50,823	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	6,498	0	6,498	0	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	578,468	467,004	578,468	239,683	26,030	30.00
31.00	03100	INTENSIVE CARE UNIT	107,892	110,978	107,892	34,501	5,436	31.00
41.00	04100	SUBPROVIDER - IRF	109,284	20,647	109,284	51,541	3,815	41.00
43.00	04300	NURSERY	91,668	4,945	91,668	0	1,387	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	499,073	135,238	499,073	0	9,221	50.00
51.00	05100	RECOVERY ROOM	28,056	24,518	28,056	0	1,139	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	50,256	9,386	50,256	0	2,244	52.00
53.00	05300	ANESTHESIOLOGY	7,848	0	7,848	0	99	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	173,633	41,294	173,633	0	6,038	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	135,756	0	135,756	0	2,125	55.00
56.00	05600	RADIOISOTOPE	33,833	0	33,833	0	622	56.00
57.00	05700	CT SCAN	22,637	0	22,637	0	859	57.00
58.00	05800	MRI	25,476	0	25,476	0	360	58.00
59.00	05900	CARDIAC CATHETERIZATION	126,660	90,331	126,660	0	1,494	59.00
60.00	06000	LABORATORY	13,251	0	13,251	0	5	60.00
65.00	06500	RESPIRATORY THERAPY	15,624	0	15,624	0	1,934	65.00
66.00	06600	PHYSICAL THERAPY	56,388	0	56,388	0	6,641	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,308	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	517	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	2,676	0	2,676	0	227	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	17,772	0	17,772	0	550	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	671	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	21,564	0	21,564	0	523	90.00
90.01	09001	DIABETES CENTER	0	0	0	0	154	90.01
91.00	09100	EMERGENCY	113,484	379,390	113,484	0	5,711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	541	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	4,066	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,524,788	1,283,731	2,478,900	325,725	90,737	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,508	0	17,508	0	0	190.00
192.01	19201	OCCUPATIONAL HEALTH	0	0	0	0	7	192.01
192.02	19202	FLIGHT FOR LIFE	0	0	0	0	0	192.02
192.04	19204	WELLNESS PROGRAM	0	0	0	0	0	192.04
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)	6,066,495	1,104,729	3,457,136	3,527,587	918,239	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.386227	0.860561	1.384844	10.829955	10.119005	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	984,131	35,064	181,982	403,129	14,410	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.387103	0.027314	0.072898	1.237636	0.158798	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1
Date/Time Prepared:
11/20/2015 1:32 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	1,092,576					13.00
14.00	01400	0	15,739,665				14.00
15.00	01500	0	0	13,997,813			15.00
16.00	01600	0	0	0	720,849,826		16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	541,429	0	0	61,856,952	0	30.00
31.00	03100	113,062	0	0	13,222,965	0	31.00
41.00	04100	79,359	0	0	8,562,883	0	41.00
43.00	04300	28,856	0	0	3,865,099	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	191,787	0	0	86,096,103	0	50.00
51.00	05100	23,685	0	0	10,414,771	0	51.00
52.00	05200	46,682	0	0	7,336,790	0	52.00
53.00	05300	2,069	0	0	10,694,807	0	53.00
54.00	05400	0	0	0	71,565,057	0	54.00
55.00	05500	0	0	0	27,726,482	0	55.00
56.00	05600	0	0	0	14,782,265	0	56.00
57.00	05700	0	0	0	53,294,735	0	57.00
58.00	05800	0	0	0	12,167,595	0	58.00
59.00	05900	0	0	0	24,476,801	0	59.00
60.00	06000	0	0	0	57,938,214	0	60.00
65.00	06500	40,230	0	0	9,276,617	0	65.00
66.00	06600	0	0	0	29,471,306	0	66.00
67.00	06700	0	0	0	5,392,283	0	67.00
68.00	06800	0	0	0	3,112,676	0	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	0	0	0	1,650,609	0	70.01
71.00	07100	0	5,853,181	0	18,512,868	0	71.00
72.00	07200	0	9,886,484	0	34,405,222	0	72.00
73.00	07300	0	0	13,997,813	77,724,955	0	73.00
76.00	03140	11,450	0	0	3,893,274	0	76.00
76.97	07697	13,967	0	0	1,939,490	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	11,075,188	0	90.00
90.01	09001	0	0	0	375,555	0	90.01
91.00	09100	0	0	0	50,565,064	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	0	0	0	3,114,923	0	97.00
101.00	10100	0	0	0	6,338,277	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		1,092,576	15,739,665	13,997,813	720,849,826	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.04	19204	0	0	0	0	0	192.04
200.00							200.00
201.00							201.00
202.00		3,739,394	2,769,062	6,282,702	4,054,409	0	202.00
203.00		3.422548	0.175929	0.448835	0.005624	0.000000	203.00
204.00		140,691	489,104	907,831	97,451	0	204.00
205.00		0.128770	0.031075	0.064855	0.000135	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140116		Period: From 07/01/2014 To 06/30/2015		Worksheet C Part I Date/Time Prepared: 11/20/2015 1:32 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		36,514,435	139,000	36,653,435	30.00	
31.00	03100 INTENSIVE CARE UNIT		9,232,445	0	9,232,445	31.00	
41.00	04100 SUBPROVIDER - I RF		6,139,039	0	6,139,039	41.00	
43.00	04300 NURSERY		3,222,779	0	3,222,779	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		20,970,700	0	20,970,700	50.00	
51.00	05100 RECOVERY ROOM		2,190,413	0	2,190,413	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		4,680,610	0	4,680,610	52.00	
53.00	05300 ANESTHESIOLOGY		729,315	23,599	752,914	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		12,232,048	117,522	12,349,570	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC		5,055,823	18,357	5,074,180	55.00	
56.00	05600 RADIOISOTOPE		2,358,206	0	2,358,206	56.00	
57.00	05700 CT SCAN		1,933,985	0	1,933,985	57.00	
58.00	05800 MRI		881,066	0	881,066	58.00	
59.00	05900 CARDIAC CATHETERIZATION		4,155,445	0	4,155,445	59.00	
60.00	06000 LABORATORY		6,887,587	0	6,887,587	60.00	
65.00	06500 RESPIRATORY THERAPY	0	2,704,418	0	2,704,418	65.00	
66.00	06600 PHYSICAL THERAPY	0	10,115,809	16,433	10,132,242	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	1,796,602	0	1,796,602	67.00	
68.00	06800 SPEECH PATHOLOGY	0	740,323	0	740,323	68.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00	
70.01	07001 SLEEP LAB/NEUROLOGY		332,733	0	332,733	70.01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		8,487,574	0	8,487,574	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		14,353,816	0	14,353,816	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		24,306,147	0	24,306,147	73.00	
76.00	03140 RADIOLOGY		909,934	0	909,934	76.00	
76.97	07697 CARDIAC REHABILITATION		1,023,611	4,728	1,028,339	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		7,239,582	18,054	7,257,636	90.00	
90.01	09001 DIABETES CENTER		208,228	1,933	210,161	90.01	
91.00	09100 EMERGENCY		9,763,952	28,211	9,792,163	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		4,476,074	0	4,476,074	92.00	
OTHER REIMBURSABLE COST CENTERS							
97.00	09700 DURABLE MEDICAL EQUIP-SOLD		1,137,585	0	1,137,585	97.00	
101.00	10100 HOME HEALTH AGENCY		5,209,350	0	5,209,350	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE					113.00	
200.00	Subtotal (see instructions)	0	209,989,634	367,837	210,357,471	200.00	
201.00	Less Observation Beds		4,476,074	0	4,476,074	201.00	
202.00	Total (see instructions)	0	205,513,560	367,837	205,881,397	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140116		Period: From 07/01/2014 To 06/30/2015		Worksheet C Part I Date/Time Prepared: 11/20/2015 1:32 pm	
			Title XVII I		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	55,564,741		55,564,741			30.00
31.00	03100	INTENSIVE CARE UNIT	13,222,965		13,222,965			31.00
41.00	04100	SUBPROVIDER - I RF	8,562,883		8,562,883			41.00
43.00	04300	NURSERY	3,865,099		3,865,099			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,140,880	54,955,223	86,096,103	0.243573	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,198,533	6,216,238	10,414,771	0.210318	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,297,834	1,038,956	7,336,790	0.637964	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,299,837	6,394,970	10,694,807	0.068193	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,177,783	59,387,274	71,565,057	0.170922	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	636,580	27,089,902	27,726,482	0.182346	0.000000	55.00
56.00	05600	RADIOISOTOPE	2,105,324	12,676,941	14,782,265	0.159529	0.000000	56.00
57.00	05700	CT SCAN	15,263,105	38,031,630	53,294,735	0.036288	0.000000	57.00
58.00	05800	MRI	2,511,407	9,656,188	12,167,595	0.072411	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,845,860	10,630,941	24,476,801	0.169771	0.000000	59.00
60.00	06000	LABORATORY	35,499,170	22,439,044	57,938,214	0.118878	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,001,990	1,274,627	9,276,617	0.291531	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,606,416	22,864,890	29,471,306	0.343243	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,483,334	908,949	5,392,283	0.333180	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,053,194	59,482	3,112,676	0.237841	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	234,728	1,415,881	1,650,609	0.201582	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,849,407	8,663,461	18,512,868	0.458469	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,868,414	10,536,808	34,405,222	0.417199	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,314,142	42,410,813	77,724,955	0.312720	0.000000	73.00
76.00	03140	CARDIOLOGY	662,697	3,230,577	3,893,274	0.233719	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	144,570	1,794,920	1,939,490	0.527773	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,536	11,072,652	11,075,188	0.653676	0.000000	90.00
90.01	09001	DIABETES CENTER	130	375,425	375,555	0.554454	0.000000	90.01
91.00	09100	EMERGENCY	13,289,840	37,275,224	50,565,064	0.193097	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,292,211	6,292,211	0.711367	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	3,114,923	3,114,923	0.365205	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	6,338,277	6,338,277			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	314,703,399	406,146,427	720,849,826			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	314,703,399	406,146,427	720,849,826			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/20/2015 1:32 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.243573		50.00
51.00	05100 RECOVERY ROOM	0.210318		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.637964		52.00
53.00	05300 ANESTHESIOLOGY	0.070400		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.172564		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.183008		55.00
56.00	05600 RADIOISOTOPE	0.159529		56.00
57.00	05700 CT SCAN	0.036288		57.00
58.00	05800 MRI	0.072411		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.169771		59.00
60.00	06000 LABORATORY	0.118878		60.00
65.00	06500 RESPIRATORY THERAPY	0.291531		65.00
66.00	06600 PHYSICAL THERAPY	0.343800		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.333180		67.00
68.00	06800 SPEECH PATHOLOGY	0.237841		68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0.201582		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.458469		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.417199		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.312720		73.00
76.00	03140 RADIOLOGY	0.233719		76.00
76.97	07697 CARDIAC REHABILITATION	0.530211		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.655306		90.00
90.01	09001 DIABETES CENTER	0.559601		90.01
91.00	09100 EMERGENCY	0.193655		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.711367		92.00
OTHER REIMBURSABLE COST CENTERS				
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.365205		97.00
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

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/20/2015 1:32 pm		
		Title XIX	Hospital	Cost		
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		36,514,435	139,000	36,653,435	30.00
31.00	03100 INTENSIVE CARE UNIT		9,232,445	0	9,232,445	31.00
41.00	04100 SUBPROVIDER - I RF		6,139,039	0	6,139,039	41.00
43.00	04300 NURSERY		3,222,779	0	3,222,779	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		20,970,700	0	20,970,700	50.00
51.00	05100 RECOVERY ROOM		2,190,413	0	2,190,413	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		4,680,610	0	4,680,610	52.00
53.00	05300 ANESTHESIOLOGY		729,315	23,599	752,914	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		12,232,048	117,522	12,349,570	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		5,055,823	18,357	5,074,180	55.00
56.00	05600 RADIOISOTOPE		2,358,206	0	2,358,206	56.00
57.00	05700 CT SCAN		1,933,985	0	1,933,985	57.00
58.00	05800 MRI		881,066	0	881,066	58.00
59.00	05900 CARDIAC CATHETERIZATION		4,155,445	0	4,155,445	59.00
60.00	06000 LABORATORY		6,887,587	0	6,887,587	60.00
65.00	06500 RESPIRATORY THERAPY	0	2,704,418	0	2,704,418	65.00
66.00	06600 PHYSICAL THERAPY	0	10,115,809	16,433	10,132,242	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,796,602	0	1,796,602	67.00
68.00	06800 SPEECH PATHOLOGY	0	740,323	0	740,323	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY		332,733	0	332,733	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		8,487,574	0	8,487,574	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		14,353,816	0	14,353,816	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		24,306,147	0	24,306,147	73.00
76.00	03140 RADIOLOGY		909,934	0	909,934	76.00
76.97	07697 CARDIAC REHABILITATION		1,023,611	4,728	1,028,339	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		7,239,582	18,054	7,257,636	90.00
90.01	09001 DIABETES CENTER		208,228	1,933	210,161	90.01
91.00	09100 EMERGENCY		9,763,952	28,211	9,792,163	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		4,476,074	0	4,476,074	92.00
OTHER REIMBURSABLE COST CENTERS						
97.00	09700 DURABLE MEDICAL EQUIP-SOLD		1,137,585	0	1,137,585	97.00
101.00	10100 HOME HEALTH AGENCY		5,209,350	0	5,209,350	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	0	209,989,634	367,837	210,357,471	200.00
201.00	Less Observation Beds		4,476,074	0	4,476,074	201.00
202.00	Total (see instructions)	0	205,513,560	367,837	205,881,397	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140116		Period: From 07/01/2014 To 06/30/2015		Worksheet C Part I Date/Time Prepared: 11/20/2015 1:32 pm	
			Title XIX		Hospital		Cost	
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	55,564,741		55,564,741			30.00
31.00	03100	INTENSIVE CARE UNIT	13,222,965		13,222,965			31.00
41.00	04100	SUBPROVIDER - IRF	8,562,883		8,562,883			41.00
43.00	04300	NURSERY	3,865,099		3,865,099			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,140,880	54,955,223	86,096,103	0.243573	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,198,533	6,216,238	10,414,771	0.210318	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,297,834	1,038,956	7,336,790	0.637964	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,299,837	6,394,970	10,694,807	0.068193	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,177,783	59,387,274	71,565,057	0.170922	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	636,580	27,089,902	27,726,482	0.182346	0.000000	55.00
56.00	05600	RADIOISOTOPE	2,105,324	12,676,941	14,782,265	0.159529	0.000000	56.00
57.00	05700	CT SCAN	15,263,105	38,031,630	53,294,735	0.036288	0.000000	57.00
58.00	05800	MRI	2,511,407	9,656,188	12,167,595	0.072411	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,845,860	10,630,941	24,476,801	0.169771	0.000000	59.00
60.00	06000	LABORATORY	35,499,170	22,439,044	57,938,214	0.118878	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,001,990	1,274,627	9,276,617	0.291531	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,606,416	22,864,890	29,471,306	0.343243	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,483,334	908,949	5,392,283	0.333180	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,053,194	59,482	3,112,676	0.237841	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	234,728	1,415,881	1,650,609	0.201582	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,849,407	8,663,461	18,512,868	0.458469	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,868,414	10,536,808	34,405,222	0.417199	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,314,142	42,410,813	77,724,955	0.312720	0.000000	73.00
76.00	03140	CARDIOLOGY	662,697	3,230,577	3,893,274	0.233719	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	144,570	1,794,920	1,939,490	0.527773	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,536	11,072,652	11,075,188	0.653676	0.000000	90.00
90.01	09001	DIABETES CENTER	130	375,425	375,555	0.554454	0.000000	90.01
91.00	09100	EMERGENCY	13,289,840	37,275,224	50,565,064	0.193097	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,292,211	6,292,211	0.711367	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	3,114,923	3,114,923	0.365205	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	6,338,277	6,338,277			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	314,703,399	406,146,427	720,849,826			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	314,703,399	406,146,427	720,849,826			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/20/2015 1:32 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0.000000		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03140 RADIOLOGY	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 DIABETES CENTER	0.000000		90.01
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
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: 140116		Period: From 07/01/2014 To 06/30/2015		Worksheet D Part I Date/Time Prepared: 11/20/2015 1:32 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,762,076	0	2,762,076	35,015	78.88	30.00
31.00	INTENSIVE CARE UNIT	539,490	0	539,490	4,499	119.91	31.00
41.00	SUBPROVIDER - IRF	510,485	0	510,485	6,721	75.95	41.00
43.00	NURSERY	348,640	0	348,640	3,608	96.63	43.00
200.00	Total (Lines 30-199)	4,160,691	0	4,160,691	49,843		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	16,196	1,277,540				
31.00	INTENSIVE CARE UNIT	2,608	312,725				
41.00	SUBPROVIDER - IRF	5,013	380,737				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	23,817	1,971,002				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part II Date/Time Prepared: 11/20/2015 1:32 pm
--	--	----------------------	---	---

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	
Title VIII Hospital PPS								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,169,831	86,096,103	0.025202	15,101,227	380,581	50.00
51.00	05100	RECOVERY ROOM	129,352	10,414,771	0.012420	1,917,881	23,820	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	239,374	7,336,790	0.032627	0	0	52.00
53.00	05300	ANESTHESIOLOGY	46,805	10,694,807	0.004376	1,885,609	8,251	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,484,437	71,565,057	0.020742	6,999,547	145,185	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	558,703	27,726,482	0.020151	360,452	7,263	55.00
56.00	05600	RADIOISOTOPE	146,723	14,782,265	0.009926	1,148,433	11,399	56.00
57.00	05700	CT SCAN	105,814	53,294,735	0.001985	8,165,384	16,208	57.00
58.00	05800	MRI	96,566	12,167,595	0.007936	1,193,862	9,474	58.00
59.00	05900	CARDIAC CATHETERIZATION	476,897	24,476,801	0.019484	7,420,661	144,584	59.00
60.00	06000	LABORATORY	152,886	57,938,214	0.002639	18,115,022	47,806	60.00
65.00	06500	RESPIRATORY THERAPY	136,978	9,276,617	0.014766	4,599,890	67,922	65.00
66.00	06600	PHYSICAL THERAPY	1,182,188	29,471,306	0.040113	2,212,357	88,744	66.00
67.00	06700	OCCUPATIONAL THERAPY	96,423	5,392,283	0.017882	1,041,784	18,629	67.00
68.00	06800	SPEECH PATHOLOGY	12,916	3,112,676	0.004149	632,589	2,625	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	67,274	1,650,609	0.040757	110,067	4,486	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	299,033	18,512,868	0.016153	5,091,037	82,236	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	505,508	34,405,222	0.014693	11,947,008	175,537	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,192,499	77,724,955	0.015343	17,324,908	265,816	73.00
76.00	03140	CARDIOLOGY	73,037	3,893,274	0.018760	374,904	7,033	76.00
76.97	07697	CARDIAC REHABILITATION	203,028	1,939,490	0.104681	77,138	8,075	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,048,463	11,075,188	0.094668	1,175	111	90.00
90.01	09001	DIABETES CENTER	35,216	375,555	0.093771	0	0	90.01
91.00	09100	EMERGENCY	543,914	50,565,064	0.010757	7,355,052	79,118	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	337,304	6,292,211	0.053607	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	19,851	3,114,923	0.006373	0	0	97.00
200.00		Total (lines 50-199)	11,361,020	633,295,861		113,075,987	1,594,903	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part III Date/Time Prepared: 11/20/2015 1:32 pm
---	--	----------------------	---	--

Cost Center Description			Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00	
43.00	04300	NURSERY	0	0	0	0	0 43.00	
200.00		Total (lines 30-199)	0	0	0	0	0 200.00	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,015	0.00	16,196	0	0 30.00	
31.00	03100	INTENSIVE CARE UNIT	4,499	0.00	2,608	0	0 31.00	
41.00	04100	SUBPROVIDER - IRF	6,721	0.00	5,013	0	0 41.00	
43.00	04300	NURSERY	3,608	0.00	0	0	0 43.00	
200.00		Total (lines 30-199)	49,843		23,817	0	0 200.00	
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
			12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00			
41.00	04100	SUBPROVIDER - IRF	0	0	41.00			
43.00	04300	NURSERY	0	0	43.00			
200.00		Total (lines 30-199)	0	0	200.00			

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet D
Part IV
Date/Time Prepared:
11/20/2015 1:32 pm

Cost Center Description		Title XVIII				Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	DIABETES CENTER	0	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet D
Part IV
Date/Time Prepared:
11/20/2015 1:32 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	86,096,103	0.000000	0.000000	15,101,227	50.00
51.00	05100	RECOVERY ROOM	0	10,414,771	0.000000	0.000000	1,917,881	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,336,790	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	10,694,807	0.000000	0.000000	1,885,609	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	71,565,057	0.000000	0.000000	6,999,547	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	27,726,482	0.000000	0.000000	360,452	55.00
56.00	05600	RADIOISOTOPE	0	14,782,265	0.000000	0.000000	1,148,433	56.00
57.00	05700	CT SCAN	0	53,294,735	0.000000	0.000000	8,165,384	57.00
58.00	05800	MRI	0	12,167,595	0.000000	0.000000	1,193,862	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	24,476,801	0.000000	0.000000	7,420,661	59.00
60.00	06000	LABORATORY	0	57,938,214	0.000000	0.000000	18,115,022	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,276,617	0.000000	0.000000	4,599,890	65.00
66.00	06600	PHYSICAL THERAPY	0	29,471,306	0.000000	0.000000	2,212,357	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,392,283	0.000000	0.000000	1,041,784	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,112,676	0.000000	0.000000	632,589	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	1,650,609	0.000000	0.000000	110,067	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	18,512,868	0.000000	0.000000	5,091,037	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	34,405,222	0.000000	0.000000	11,947,008	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	77,724,955	0.000000	0.000000	17,324,908	73.00
76.00	03140	CARDIOLOGY	0	3,893,274	0.000000	0.000000	374,904	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,939,490	0.000000	0.000000	77,138	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	11,075,188	0.000000	0.000000	1,175	90.00
90.01	09001	DIABETES CENTER	0	375,555	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	50,565,064	0.000000	0.000000	7,355,052	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,292,211	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	3,114,923	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	633,295,861			113,075,987	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/20/2015 1:32 pm
--	----------------------	---	---

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
Title XVIIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	15,561,976	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0	1,108,775	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	1,356,877	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,456,985	0	0	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	11,158,389	0	0	0 55.00
56.00	05600	RADIOISOTOPE	0	5,774,708	0	0	0 56.00
57.00	05700	CT SCAN	0	11,269,188	0	0	0 57.00
58.00	05800	MRI	0	2,791,581	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,970,980	0	0	0 59.00
60.00	06000	LABORATORY	0	5,999,426	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	462,536	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	780	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	129	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	413,324	0	0	0 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,766,988	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,345,605	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,670,563	0	0	0 73.00
76.00	03140	CARDIOLOGY	0	1,223,339	0	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	897,663	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	5,243,286	0	0	0 90.00
90.01	09001	DIABETES CENTER	0	39,058	0	0	0 90.01
91.00	09100	EMERGENCY	0	7,261,818	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,293,938	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0 97.00
200.00		Total (lines 50-199)	0	114,067,912	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/20/2015 1:32 pm
	Title XVIII	Hospital	PPS

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost		
	23.00	24.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01 07001 SLEEP LAB/NEUROLOGY	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00 03140 RADIOLOGY	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 DIABETES CENTER	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00 Total (Lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/20/2015 1:32 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.243573	15,561,976	0	0	3,790,477	50.00
51.00	05100 RECOVERY ROOM	0.210318	1,108,775	0	0	233,195	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.637964	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.068193	1,356,877	0	0	92,530	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.170922	15,456,985	30,564	0	2,641,939	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.182346	11,158,389	0	0	2,034,688	55.00
56.00	05600 RADIOISOTOPE	0.159529	5,774,708	0	0	921,233	56.00
57.00	05700 CT SCAN	0.036288	11,269,188	0	0	408,936	57.00
58.00	05800 MRI	0.072411	2,791,581	0	0	202,141	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.169771	4,970,980	0	0	843,928	59.00
60.00	06000 LABORATORY	0.118878	5,999,426	343	0	713,200	60.00
65.00	06500 RESPIRATORY THERAPY	0.291531	462,536	427	0	134,844	65.00
66.00	06600 PHYSICAL THERAPY	0.343243	780	0	0	268	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.333180	129	0	0	43	67.00
68.00	06800 SPEECH PATHOLOGY	0.237841	0	0	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0.201582	413,324	0	0	83,319	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.458469	1,766,988	0	0	810,109	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.417199	4,345,605	0	0	1,812,982	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.312720	14,670,563	60	172,636	4,587,778	73.00
76.00	03140 RADIOLOGY	0.233719	1,223,339	0	0	285,918	76.00
76.97	07697 CARDIAC REHABILITATION	0.527773	897,663	0	0	473,762	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.653676	5,243,286	0	0	3,427,410	90.00
90.01	09001 DIABETES CENTER	0.554454	39,058	0	0	21,656	90.01
91.00	09100 EMERGENCY	0.193097	7,261,818	0	0	1,402,235	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.711367	2,293,938	0	1,443	1,631,832	92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.365205	0	0	0	0	97.00
200.00	Subtotal (see instructions)		114,067,912	31,394	174,079	26,554,423	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		114,067,912	31,394	174,079	26,554,423	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/20/2015 1:32 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
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	5,224	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	41	0		60.00
65.00 06500 RESPIRATORY THERAPY	124	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01 07001 SLEEP LAB/NEUROLOGY	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	19	53,987		73.00
76.00 03140 RADIOLOGY	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 DIABETES CENTER	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1,027		92.00
OTHER REIMBURSABLE COST CENTERS				
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00 Subtotal (see instructions)	5,408	55,014		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	5,408	55,014		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140116 Component CCN: 14T116		Period: From 07/01/2014 To 06/30/2015		Worksheet D Part II Date/Time Prepared: 11/20/2015 1:32 pm		
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,169,831	86,096,103	0.025202	8,563	216	50.00
51.00	05100	RECOVERY ROOM	129,352	10,414,771	0.012420	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	239,374	7,336,790	0.032627	0	0	52.00
53.00	05300	ANESTHESIOLOGY	46,805	10,694,807	0.004376	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,484,437	71,565,057	0.020742	150,057	3,112	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	558,703	27,726,482	0.020151	111,955	2,256	55.00
56.00	05600	RADIOISOTOPE	146,723	14,782,265	0.009926	6,494	64	56.00
57.00	05700	CT SCAN	105,814	53,294,735	0.001985	71,702	142	57.00
58.00	05800	MRI	96,566	12,167,595	0.007936	25,373	201	58.00
59.00	05900	CARDIAC CATHETERIZATION	476,897	24,476,801	0.019484	0	0	59.00
60.00	06000	LABORATORY	152,886	57,938,214	0.002639	1,115,856	2,945	60.00
65.00	06500	RESPIRATORY THERAPY	136,978	9,276,617	0.014766	234,432	3,462	65.00
66.00	06600	PHYSICAL THERAPY	1,182,188	29,471,306	0.040113	2,225,294	89,263	66.00
67.00	06700	OCCUPATIONAL THERAPY	96,423	5,392,283	0.017882	2,104,720	37,637	67.00
68.00	06800	SPEECH PATHOLOGY	12,916	3,112,676	0.004149	1,704,942	7,074	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	67,274	1,650,609	0.040757	4,538	185	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	299,033	18,512,868	0.016153	13,879	224	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	505,508	34,405,222	0.014693	1,147	17	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,192,499	77,724,955	0.015343	1,276,404	19,584	73.00
76.00	03140	CARDIOLOGY	73,037	3,893,274	0.018760	2,018	38	76.00
76.97	07697	CARDIAC REHABILITATION	203,028	1,939,490	0.104681	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,048,463	11,075,188	0.094668	0	0	90.00
90.01	09001	DIABETES CENTER	35,216	375,555	0.093771	0	0	90.01
91.00	09100	EMERGENCY	543,914	50,565,064	0.010757	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,292,211	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	19,851	3,114,923	0.006373	0	0	97.00
200.00		Total (lines 50-199)	11,023,716	633,295,861		9,057,374	166,420	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140116 Component CCN: 14T116	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/20/2015 1:32 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	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
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01 07001 SLEEP LAB/NEUROLOGY	0	0	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03140 RADIOLOGY	0	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 DIABETES CENTER	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
OTHER REIMBURSABLE COST CENTERS						
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 140116 Component CCN: 14T116	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/20/2015 1:32 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	86,096,103	0.000000	0.000000	8,563	50.00
51.00	05100 RECOVERY ROOM	0	10,414,771	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	7,336,790	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	10,694,807	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	71,565,057	0.000000	0.000000	150,057	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	27,726,482	0.000000	0.000000	111,955	55.00
56.00	05600 RADIOISOTOPE	0	14,782,265	0.000000	0.000000	6,494	56.00
57.00	05700 CT SCAN	0	53,294,735	0.000000	0.000000	71,702	57.00
58.00	05800 MRI	0	12,167,595	0.000000	0.000000	25,373	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	24,476,801	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	57,938,214	0.000000	0.000000	1,115,856	60.00
65.00	06500 RESPIRATORY THERAPY	0	9,276,617	0.000000	0.000000	234,432	65.00
66.00	06600 PHYSICAL THERAPY	0	29,471,306	0.000000	0.000000	2,225,294	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	5,392,283	0.000000	0.000000	2,104,720	67.00
68.00	06800 SPEECH PATHOLOGY	0	3,112,676	0.000000	0.000000	1,704,942	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0	1,650,609	0.000000	0.000000	4,538	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	18,512,868	0.000000	0.000000	13,879	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	34,405,222	0.000000	0.000000	1,147	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	77,724,955	0.000000	0.000000	1,276,404	73.00
76.00	03140 RADIOLOGY	0	3,893,274	0.000000	0.000000	2,018	76.00
76.97	07697 CARDIAC REHABILITATION	0	1,939,490	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	11,075,188	0.000000	0.000000	0	90.00
90.01	09001 DIABETES CENTER	0	375,555	0.000000	0.000000	0	90.01
91.00	09100 EMERGENCY	0	50,565,064	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	6,292,211	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	3,114,923	0.000000	0.000000	0	97.00
200.00	Total (lines 50-199)	0	633,295,861			9,057,374	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140116 Component CCN: 14T116	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/20/2015 1:32 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
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	1,032	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	2,438	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	129	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0	0	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	702	0	0	0	73.00
76.00	03140 RADIOLOGY	0	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 DIABETES CENTER	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
OTHER REIMBURSABLE COST CENTERS							
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00	Total (lines 50-199)	0	4,301	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140116 Component CCN: 14T116	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/20/2015 1:32 pm PPS
Title XVIII		Subprovider - IRF	

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03140 CARDIOLOGY	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 DIABETES CENTER	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140116 Component CCN: 14T116	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/20/2015 1:32 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.243573	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.210318	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.637964	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.068193	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.170922	1,032	0	0	176	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.182346	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0.159529	0	0	0	0	56.00
57.00 05700 CT SCAN	0.036288	2,438	0	0	88	57.00
58.00 05800 MRI	0.072411	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.169771	0	0	0	0	59.00
60.00 06000 LABORATORY	0.118878	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.291531	129	0	0	38	65.00
66.00 06600 PHYSICAL THERAPY	0.343243	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.333180	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.237841	0	0	0	0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01 07001 SLEEP LAB/NEUROLOGY	0.201582	0	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.458469	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.417199	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.312720	702	0	782	220	73.00
76.00 03140 RADIOLOGY	0.233719	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0.527773	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.653676	0	0	0	0	90.00
90.01 09001 DIABETES CENTER	0.554454	0	0	0	0	90.01
91.00 09100 EMERGENCY	0.193097	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.711367	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0.365205	0	0	0	0	97.00
200.00	Subtotal (see instructions)		4,301	0	782	522 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		4,301	0	782	522 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/20/2015 1:32 pm
	Component CCN: 14T116	Title XVIII	Subprovider - IRF

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01 07001 SLEEP LAB/NEUROLOGY	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	245	73.00
76.00 03140 RADIOLOGY	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
90.01 09001 DIABETES CENTER	0	0	90.01
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS			
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
200.00 Subtotal (see instructions)	0	245	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	245	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/20/2015 1:32 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		35,015	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		35,015	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)		30,739	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)		16,196	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)		36,653,435	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)		36,653,435	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)		36,653,435	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)		1,046.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		16,953,811	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)		16,953,811	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/20/2015 1:32 pm	
Cost Center Description			Title XVIII		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,232,445	4,499	2,052.11	2,608	5,351,903
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)				26,378,659	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				48,684,373	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				1,590,265	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				1,594,903	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				3,185,168	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				45,499,205	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)				4,276	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,046.79	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				4,476,074	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140116		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/20/2015 1:32 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,762,076	36,653,435	0.075357	4,476,074	337,304	90.00
91.00	Nursing School cost	0	36,653,435	0.000000	4,476,074	0	91.00
92.00	Allied health cost	0	36,653,435	0.000000	4,476,074	0	92.00
93.00	All other Medical Education	0	36,653,435	0.000000	4,476,074	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1
		Component CCN: 14T116		Date/Time Prepared: 11/20/2015 1:32 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,721	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,721	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,721	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)		5,013	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)		6,139,039	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)		6,139,039	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)		6,139,039	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)		913.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,578,924	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,578,924	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140116		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1	
		Component CCN: 14T116				Date/Time Prepared: 11/20/2015 1:32 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,534,137		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,113,061		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)					380,737		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					166,420		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					547,157		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,565,904		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140116 Component CCN: 14T116		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/20/2015 1:32 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	510,485	6,139,039	0.083154	0	0	90.00
91.00	Nursing School cost	0	6,139,039	0.000000	0	0	91.00
92.00	Allied health cost	0	6,139,039	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,139,039	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Prepared: 11/20/2015 1:32 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		30,273,244	30.00
31.00	03100	INTENSIVE CARE UNIT		7,695,600	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.243573	15,101,227	50.00
51.00	05100	RECOVERY ROOM	0.210318	1,917,881	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.637964	0	52.00
53.00	05300	ANESTHESIOLOGY	0.070400	1,885,609	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.172564	6,999,547	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.183008	360,452	55.00
56.00	05600	RADIOISOTOPE	0.159529	1,148,433	56.00
57.00	05700	CT SCAN	0.036288	8,165,384	57.00
58.00	05800	MRI	0.072411	1,193,862	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.169771	7,420,661	59.00
60.00	06000	LABORATORY	0.118878	18,115,022	60.00
65.00	06500	RESPIRATORY THERAPY	0.291531	4,599,890	65.00
66.00	06600	PHYSICAL THERAPY	0.343800	2,212,357	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.333180	1,041,784	67.00
68.00	06800	SPEECH PATHOLOGY	0.237841	632,589	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0.201582	110,067	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.458469	5,091,037	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.417199	11,947,008	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.312720	17,324,908	73.00
76.00	03140	CARDIOLOGY	0.233719	374,904	76.00
76.97	07697	CARDIAC REHABILITATION	0.530211	77,138	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.655306	1,175	90.00
90.01	09001	DIABETES CENTER	0.559601	0	90.01
91.00	09100	EMERGENCY	0.193655	7,355,052	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.711367	0	92.00
OTHER REIMBURSABLE COST CENTERS					
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.365205	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		113,075,987	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)		113,075,987	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3	
		Component CCN: 14T116		Date/Time Prepared: 11/20/2015 1:32 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		6,419,353		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.243573	8,563	2,086	50.00
51.00	05100 RECOVERY ROOM	0.210318	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.637964	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.070400	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.172564	150,057	25,894	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.183008	111,955	20,489	55.00
56.00	05600 RADIOISOTOPE	0.159529	6,494	1,036	56.00
57.00	05700 CT SCAN	0.036288	71,702	2,602	57.00
58.00	05800 MRI	0.072411	25,373	1,837	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.169771	0	0	59.00
60.00	06000 LABORATORY	0.118878	1,115,856	132,651	60.00
65.00	06500 RESPIRATORY THERAPY	0.291531	234,432	68,344	65.00
66.00	06600 PHYSICAL THERAPY	0.343800	2,225,294	765,056	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.333180	2,104,720	701,251	67.00
68.00	06800 SPEECH PATHOLOGY	0.237841	1,704,942	405,505	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0.201582	4,538	915	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.458469	13,879	6,363	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.417199	1,147	479	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.312720	1,276,404	399,157	73.00
76.00	03140 RADIOLOGY	0.233719	2,018	472	76.00
76.97	07697 CARDIAC REHABILITATION	0.530211	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.655306	0	0	90.00
90.01	09001 DIABETES CENTER	0.559601	0	0	90.01
91.00	09100 EMERGENCY	0.193655	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.711367	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.365205	0	0	97.00
200.00	Total (sum of lines 50-94 and 96-98)		9,057,374	2,534,137	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)		9,057,374		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prepared: 11/20/2015 1:32 pm	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		9,543,907		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		29,038,343		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)		716,286		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)		144.95		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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prepared: 11/20/2015 1:32 pm		
		Title XVIII	Hospital		PPS	
		0	before 1/1	on/after 1/1	2.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		1.00	1.01		29.01
Disproportionate Share Adjustment						
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.76			30.00
31.00	Percentage of Medicaid patient days (see instructions)		16.45			31.00
32.00	Sum of lines 30 and 31		18.21			32.00
33.00	Allowable disproportionate share percentage (see instructions)		4.59			33.00
34.00	Disproportionate share adjustment (see instructions)		442,731			34.00
			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
Uncompensated Care Adjustment						
35.00	Total uncompensated care amount (see instructions)		9,046,380,143		7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000140792		0.000122682	35.01
35.02	Hospital uncompensated care payment (if line 34 is zero, enter zero on this line) (see instructions)		1,273,658		938,228	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		321,032		701,743	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,022,775			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)						
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	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)		40,764,042			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)		40,764,042			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,255,129			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		44,019,171			59.00
60.00	Primary payer payments		32,136			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		43,987,035			61.00
62.00	Deductibles billed to program beneficiaries		3,755,444			62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prepared: 11/20/2015 1:32 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00
63.00	Coinsurance billed to program beneficiaries		75,844		63.00
64.00	Allowable bad debts (see instructions)		607,286		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		394,736		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		367,340		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		40,550,483		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		9,294		70.93
70.94	HRR adjustment amount (see instructions)		-318,993		70.94
70.95	Recovery of accelerated depreciation		0		70.95
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)		40,240,784		71.00
71.01	Sequestration adjustment (see instructions)		804,816		71.01
72.00	Interim payments		37,938,078		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)		1,497,890		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		12,539		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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prepared: 11/20/2015 1:32 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1		On/After 10/1
		1.00	1.01	2.00
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0		0
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0		0
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0		0
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000		0.0000
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0		0

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140116		Period: From 07/01/2014 To 06/30/2015		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 11/20/2015 1:32 pm	
		PPS					
		Original .mcrcx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	1.76	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	16.45	0.00			16.45	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	18.21	0.00			16.45	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	144.95	0.00			144.95	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	4.59	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	1.76	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	2,626	0			2,626	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	791	0			791	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	23	0			23	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	2,825	0			2,825	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	211	0			211	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	6,476	0			6,476	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	38,846	0			38,846	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	516	0			516	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	39,362	0			39,362	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	16.45	0.00			16.45	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140116		Period: From 07/01/2014 To 06/30/2015		Worksheet DSH Date/Time Prepared: 11/20/2015 1:32 pm	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	False	0.00		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	True	4.59		0.00	True	29.00
30.00	Line 28 or 29 as applicable		4.59		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		0.00		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet DSH Date/Time Prepared: 11/20/2015 1:32 pm
		Title XVIII	Hospital	PPS

		Revised Percentage	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE		6.00	
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	3.44	29.00
30.00	Line 28 or 29 as applicable	3.44	30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00	31.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/20/2015 1:32 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	9,543,907	0	9,543,907	0	9,543,907	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	29,038,343	0	0	29,038,343	29,038,343	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	716,286	0	183,947	532,339	716,286	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0459	0.0459	0.0459	0.0459		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	442,731	0	109,516	333,215	442,731	11.00
11.01	Uncompensated care payments	36.00	1,022,775	0	321,032	701,743	1,022,775	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	40,764,042	0	10,158,402	30,605,640	40,764,042	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	40,764,042	0	10,158,402	30,605,640	40,764,042	15.00
16.00	Payment for inpatient program capital	50.00	3,255,129	0	804,851	2,450,278	3,255,129	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/20/2015 1:32 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	10,963,253	33,055,918	44,019,171	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	3,084,339	0	762,732	2,321,607	3,084,339	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	54,819	0	13,440	41,379	54,819	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0376	0.0376	0.0376	0.0376		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	115,971	0	28,679	87,292	115,971	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,255,129	0	804,851	2,450,278	3,255,129	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/20/2015 1:32 pm
---	--	----------------------	---	--

		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	9,543,907	9,543,907		9,543,907	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	29,038,343		29,038,343	29,038,343	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	716,286	183,947	532,339	716,286	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0459	0.0459	0.0459		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	442,731	109,516	333,215	442,731	11.00
11.01	Uncompensated care payments	36.00	1,022,775	321,032	701,743	1,022,775	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	40,764,042	10,158,402	30,605,640	40,764,042	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	40,764,042	10,158,402	30,605,640	40,764,042	15.00
16.00	Payment for inpatient program capital	50.00	3,255,129	804,851	2,450,278	3,255,129	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			10,963,253	33,055,918	44,019,171	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/20/2015 1:32 pm
		Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	3,084,339	762,732	2,321,607	3,084,339	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	54,819	13,440	41,379	54,819	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0376	0.0376	0.0376		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	115,971	28,679	87,292	115,971	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,255,129	804,851	2,450,278	3,255,129	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	9,294	-5,787	15,081	9,294	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-318,993	-98,302	-220,691	-318,993	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/20/2015 1:32 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		60,422	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		26,554,423	2.00
3.00	PPS payments		22,773,451	3.00
4.00	Outlier payment (see instructions)		16,195	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		60,422	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		205,473	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)		205,473	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		205,473	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		145,051	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		60,422	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)		22,789,646	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		1,600	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		4,829,271	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)		18,019,197	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)		18,019,197	30.00
31.00	Primary payer payments		6,678	31.00
32.00	Subtotal (line 30 minus line 31)		18,012,519	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)		576,264	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		374,572	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		387,038	36.00
37.00	Subtotal (see instructions)		18,387,091	37.00
38.00	MSP-LCC reconciliation amount from PS&R		305	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)		18,386,786	40.00
40.01	Sequestration adjustment (see instructions)		367,736	40.01
41.00	Interim payments		17,961,290	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		57,760	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
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0.112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/20/2015 1:32 pm
		Component CCN: 14T116	Title XVIII	Subprovider - IRF
		PPS		
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		245	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		522	2.00
3.00	PPS payments		729	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		245	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		782	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)		782	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		782	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		537	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		245	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)		729	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)		135	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)		839	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)		839	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		839	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		839	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)		839	40.00
40.01	Sequestration adjustment (see instructions)		17	40.01
41.00	Interim payments		793	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		29	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
		Overrides		
		1.00		
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)		0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
11/20/2015 1:32 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		37,856,996		17,951,988	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	02/24/2015	81,082	02/24/2015	9,302	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		81,082		9,302	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)		37,938,078		17,961,290	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		1,497,890		57,760	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		39,435,968		18,019,050	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140116
Component CCN: 14T116

Period:
From 07/01/2014
To 06/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
11/20/2015 1:32 pm

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		6,646,047		793	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		0		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	02/24/2015	3,360		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		3,360		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,649,407		793	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		17,731		29	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,667,138		822	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: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet E-1
Part II
Date/Time Prepared:
11/20/2015 1:32 pm

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			9,304 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			18,804 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			2,192 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			35,238 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			720,849,826 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			8,614,085 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,642,120 8.00
9.00	Sequestration adjustment amount (see instructions)			32,842 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,609,278 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,618,471 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)			-9,193 32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140116 Component CCN: 14T116	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part III Date/Time Prepared: 11/20/2015 1:32 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			6,682,167 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0000 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			97,560 3.00
4.00	Outlier Payments			85,496 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			18.413699 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			6,865,223 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			6,865,223 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			6,865,223 19.00
20.00	Deductibles			38,136 20.00
21.00	Subtotal (line 19 minus line 20)			6,827,087 21.00
22.00	Coinsurance			32,975 22.00
23.00	Subtotal (line 21 minus line 22)			6,794,112 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			13,984 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			9,090 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			13,984 26.00
27.00	Subtotal (sum of lines 23 and 25)			6,803,202 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			6,803,202 32.00
32.01	Sequestration adjustment (see instructions)			136,064 32.01
33.00	Interim payments			6,649,407 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)			17,731 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			145,671 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			85,496 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet G

Date/Time Prepared:
11/20/2015 1:32 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-915,000	0	0	0	1.00
2.00	Temporary investments	12,914,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	40,334,000	0	0	0	4.00
5.00	Other receivable	64,573,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	6,002,000	0	0	0	7.00
8.00	Prepaid expenses	2,071,000	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	124,979,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	65,000	0	0	0	12.00
13.00	Land improvements	1,764,249	0	0	0	13.00
14.00	Accumulated depreciation	-1,639,244	0	0	0	14.00
15.00	Buildings	83,339,494	0	0	0	15.00
16.00	Accumulated depreciation	-42,346,002	0	0	0	16.00
17.00	Leasehold improvements	77,154	0	0	0	17.00
18.00	Accumulated depreciation	-75,874	0	0	0	18.00
19.00	Fixed equipment	12,588,902	0	0	0	19.00
20.00	Accumulated depreciation	-12,577,715	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	102,677,067	0	0	0	23.00
24.00	Accumulated depreciation	-86,695,794	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	9,071,668	0	0	0	27.00
28.00	Accumulated depreciation	-3,147,905	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)	63,101,000	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	100,687,000	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	8,760,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	109,447,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	297,527,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,345,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	13,911,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	9,671,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	25,927,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	95,881,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,518,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	98,399,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	124,326,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	173,201,000				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)	173,201,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	297,527,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet G-1

Date/Time Prepared:
11/20/2015 1:32 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		177,521,000		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		32,712,000			2.00
3.00	Total (sum of line 1 and line 2)		210,233,000		0	3.00
4.00	UNRESTRICTED NET ASSETS RELEASED	1,770,000		0		4.00
5.00	CHANGES IN TEMP RESTRICTED ASSETS	2,003,000		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		3,773,000		0	10.00
11.00	Subtotal (line 3 plus line 10)		214,006,000		0	11.00
12.00	CHANGES IN UNREALIZED LOSSES	14,805,000		0		12.00
13.00	TRANSFER TO AFFILIATED ORGANIZATION	26,000,000		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		40,805,000		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		173,201,000		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	UNRESTRICTED NET ASSETS RELEASED		0			4.00
5.00	CHANGES IN TEMP RESTRICTED ASSETS		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	CHANGES IN UNREALIZED LOSSES		0			12.00
13.00	TRANSFER TO AFFILIATED ORGANIZATION		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: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/20/2015 1:32 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	59,429,840		59,429,840	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	8,562,883		8,562,883	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)	67,992,723		67,992,723	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	13,222,965		13,222,965	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)	13,222,965		13,222,965	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	81,215,688		81,215,688	17.00
18.00	Ancillary services	220,195,203	341,677,716	561,872,919	18.00
19.00	Outpatient services	13,292,507	55,015,512	68,308,019	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		6,338,277	6,338,277	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	DME & OCC HLTH	0	3,115,253	3,115,253	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	314,703,398	406,146,758	720,850,156	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		235,104,389		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)		235,104,389		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140116

Period:
From 07/01/2014
To 06/30/2015

Worksheet G-3

Date/Time Prepared:
11/20/2015 1:32 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	720,850,156	1.00
2.00	Less contractual allowances and discounts on patients' accounts	472,539,632	2.00
3.00	Net patient revenues (line 1 minus line 2)	248,310,524	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	235,104,389	4.00
5.00	Net income from service to patients (line 3 minus line 4)	13,206,135	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	-287,157	6.00
7.00	Income from investments	12,270,466	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	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	7,521,704	24.00
24.01	ROUNDING	852	24.01
25.00	Total other income (sum of lines 6-24)	19,505,865	25.00
26.00	Total (line 5 plus line 25)	32,712,000	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	32,712,000	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140116

Period: From 07/01/2014

Worksheet H

HHA CCN: 147455

To 06/30/2015

Date/Time Prepared: 11/20/2015 1:32 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 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		0	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	703,719	0	0	158,514	862,233	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,151,598	0	83,982	0	1,235,580	6.00
7.00	Physical Therapy	723,940	0	54,818	0	778,758	7.00
8.00	Occupational Therapy	110,457	0	7,678	0	118,135	8.00
9.00	Speech Pathology	49,808	0	3,462	0	53,270	9.00
10.00	Medical Social Services	40,478	0	570	0	41,048	10.00
11.00	Home Health Aide	103,518	0	12,515	0	116,033	11.00
12.00	Supplies (see instructions)	0	0	0	112,893	112,893	12.00
13.00	Drugs	0	0	0	10,016	10,016	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	2,883,518	0	163,025	0	3,046,543	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	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	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	59,124	921,357	-51,869	869,488	847,122	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	1,235,580	0	1,235,580	1,235,580	6.00
7.00	Physical Therapy	0	778,758	0	778,758	778,758	7.00
8.00	Occupational Therapy	0	118,135	0	118,135	118,135	8.00
9.00	Speech Pathology	0	53,270	0	53,270	53,270	9.00
10.00	Medical Social Services	0	41,048	0	41,048	41,048	10.00
11.00	Home Health Aide	0	116,033	0	116,033	116,033	11.00
12.00	Supplies (see instructions)	0	112,893	0	112,893	112,893	12.00
13.00	Drugs	0	10,016	0	10,016	10,016	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	59,124	3,387,090	-51,869	3,335,221	3,387,090	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: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet H-1 Part I Date/Time Prepared: 11/20/2015 1:32 pm
		HHA CCN: 147455	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0		0		0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	869,488	0	0	0	869,488	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	1,235,580	0	0	0	1,235,580	6.00	
7.00	Physical Therapy	778,758	0	0	0	778,758	7.00	
8.00	Occupational Therapy	118,135	0	0	0	118,135	8.00	
9.00	Speech Pathology	53,270	0	0	0	53,270	9.00	
10.00	Medical Social Services	41,048	0	0	0	41,048	10.00	
11.00	Home Health Aide	116,033	0	0	0	116,033	11.00	
12.00	Supplies (see instructions)	112,893	0	0	0	112,893	12.00	
13.00	Drugs	10,016	0	0	0	10,016	13.00	
14.00	DME	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
24.00	Total (sum of lines 1-23)	3,335,221	0	0	0	3,335,221	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	869,488					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	435,699	1,671,279				6.00	
7.00	Physical Therapy	274,613	1,053,371				7.00	
8.00	Occupational Therapy	41,658	159,793				8.00	
9.00	Speech Pathology	18,785	72,055				9.00	
10.00	Medical Social Services	14,475	55,523				10.00	
11.00	Home Health Aide	40,917	156,950				11.00	
12.00	Supplies (see instructions)	39,809	152,702				12.00	
13.00	Drugs	3,532	13,548				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)		3,335,221				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 140116 HHA CCN: 147455	Period: From 07/01/2014 To 06/30/2015	Worksheet H-1 Part II Date/Time Prepared: 11/20/2015 1:32 pm PPS
			Home Health Agency I	

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			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	0	0	0	0	-869,488	2,465,733
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	1,235,580
7.00	Physical Therapy	0	0	0	0	0	778,758
8.00	Occupational Therapy	0	0	0	0	0	118,135
9.00	Speech Pathology	0	0	0	0	0	53,270
10.00	Medical Social Services	0	0	0	0	0	41,048
11.00	Home Health Aide	0	0	0	0	0	116,033
12.00	Supplies (see instructions)	0	0	0	0	0	112,893
13.00	Drugs	0	0	0	0	0	10,016
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-869,488	2,465,733
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		869,488
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.352629

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140116

Period: From 07/01/2014

Worksheet H-2

HHA CCN: 147455

To 06/30/2015

Part I
Date/Time Prepared: 11/20/2015 1:32 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP					
		1.00	2.00	4.00				
1.00 Administrative and General	0	0	0	750,035	750,035	192,280	1.00	
2.00 Skilled Nursing Care	1,671,279	0	0	0	1,671,279	428,453	2.00	
3.00 Physical Therapy	1,053,371	0	0	0	1,053,371	270,044	3.00	
4.00 Occupational Therapy	159,793	0	0	0	159,793	40,965	4.00	
5.00 Speech Pathology	72,055	0	0	0	72,055	18,472	5.00	
6.00 Medical Social Services	55,523	0	0	0	55,523	14,234	6.00	
7.00 Home Health Aide	156,950	0	0	0	156,950	40,236	7.00	
8.00 Supplies (see instructions)	152,702	0	0	0	152,702	39,147	8.00	
9.00 Drugs	13,548	0	0	0	13,548	3,473	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)	3,335,221	0	0	750,035	4,085,256	1,047,304	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	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
	7.00	8.00	9.00	10.00	11.00	13.00		
1.00 Administrative and General	0	0	0	0	41,144	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	0	41,144	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: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet H-2 Part I Date/Time Prepared: 11/20/2015 1:32 pm
		HHA CCN: 147455	Home Health Agency I	PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	17.00	24.00	25.00	
1.00	Administrative and General	0	0	35,646	0	1,019,105	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	2,099,732	0	2.00
3.00	Physical Therapy	0	0	0	0	1,323,415	0	3.00
4.00	Occupational Therapy	0	0	0	0	200,758	0	4.00
5.00	Speech Pathology	0	0	0	0	90,527	0	5.00
6.00	Medical Social Services	0	0	0	0	69,757	0	6.00
7.00	Home Health Aide	0	0	0	0	197,186	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	191,849	0	8.00
9.00	Drugs	0	0	0	0	17,021	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	35,646	0	5,209,350	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
Cost Center Description		Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs				
		26.00	27.00	28.00				
1.00	Administrative and General	1,019,105						1.00
2.00	Skilled Nursing Care	2,099,732	510,674	2,610,406				2.00
3.00	Physical Therapy	1,323,415	321,866	1,645,281				3.00
4.00	Occupational Therapy	200,758	48,826	249,584				4.00
5.00	Speech Pathology	90,527	22,017	112,544				5.00
6.00	Medical Social Services	69,757	16,966	86,723				6.00
7.00	Home Health Aide	197,186	47,957	245,143				7.00
8.00	Supplies (see instructions)	191,849	46,659	238,508				8.00
9.00	Drugs	17,021	4,140	21,161				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
20.00	Total (sum of lines 1-19) (2)	5,209,350	1,019,105	5,209,350				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.		0.243209					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: 140116
HHA CCN: 147455

Period: 07/01/2014 To 06/30/2015

Worksheet H-2 Part II
Date/Time Prepared: 11/20/2015 1:32 pm
PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					
1.00 Administrative and General	0	0	2,942,642	0	750,035	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	1,671,279	0	2.00
3.00 Physical Therapy	0	0	0	0	1,053,371	0	3.00
4.00 Occupational Therapy	0	0	0	0	159,793	0	4.00
5.00 Speech Pathology	0	0	0	0	72,055	0	5.00
6.00 Medical Social Services	0	0	0	0	55,523	0	6.00
7.00 Home Health Aide	0	0	0	0	156,950	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	152,702	0	8.00
9.00 Drugs	0	0	0	0	13,548	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	2,942,642		4,085,256	0	20.00
21.00 Total cost to be allocated	0	0	750,035		1,047,304	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.254885		0.256362	0.000000	22.00
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
1.00 Administrative and General	0	0	0	4,066	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)	0	0	0	4,066	0	0	20.00
21.00 Total cost to be allocated	0	0	0	41,144	0	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	10.119036	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140116
HHA CCN: 147455

Period:
From 07/01/2014
To 06/30/2015

Worksheet H-2
Part II
Date/Time Prepared:
11/20/2015 1:32 pm
PPS

Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)		
	15.00	16.00	17.00		
1.00 Administrative and General	0	6,338,277	0		1.00
2.00 Skilled Nursing Care	0	0	0		2.00
3.00 Physical Therapy	0	0	0		3.00
4.00 Occupational Therapy	0	0	0		4.00
5.00 Speech Pathology	0	0	0		5.00
6.00 Medical Social Services	0	0	0		6.00
7.00 Home Health Aide	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0		8.00
9.00 Drugs	0	0	0		9.00
10.00 DME	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0		13.00
14.00 Clinic	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0		15.00
16.00 Day Care Program	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0		17.00
18.00 Homemaker Service	0	0	0		18.00
19.00 All Others (specify)	0	0	0		19.00
20.00 Total (sum of lines 1-19)	0	6,338,277	0		20.00
21.00 Total cost to be allocated	0	35,646	0		21.00
22.00 Unit cost multiplier	0.000000	0.005624	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS			Provider CCN: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet H-3 Part I Date/Time Prepared: 11/20/2015 1:32 pm
			HHA CCN: 147455	Title XVIII	Home Health Agency I

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	2,610,406		2,610,406	16,495	158.25	1.00
2.00	Physical Therapy	3.00	1,645,281	0	1,645,281	10,767	152.81	2.00
3.00	Occupational Therapy	4.00	249,584	0	249,584	1,508	165.51	3.00
4.00	Speech Pathology	5.00	112,544	0	112,544	680	165.51	4.00
5.00	Medical Social Services	6.00	86,723		86,723	112	774.31	5.00
6.00	Home Health Aide	7.00	245,143		245,143	2,458	99.73	6.00
7.00	Total (sum of lines 1-6)		4,949,681	0	4,949,681	32,020		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		Ratio (col. 3 + col. 4)
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		16974	0	10,941		8.00
8.01	Skilled Nursing Care		29404	0	931		8.01
9.00	Physical Therapy		16974	0	6,808		9.00
9.01	Physical Therapy		29404	0	460		9.01
10.00	Occupational Therapy		16974	0	999		10.00
10.01	Occupational Therapy		29404	0	80		10.01
11.00	Speech Pathology		16974	0	515		11.00
11.01	Speech Pathology		29404	0	25		11.01
12.00	Medical Social Services		16974	0	76		12.00
12.01	Medical Social Services		29404	0	8		12.01
13.00	Home Health Aide		16974	0	2,143		13.00
13.01	Home Health Aide		29404	0	240		13.01
14.00	Total (sum of lines 8-13)			0	23,226		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	238,508	0	238,508	229,973	1.037113	15.00
16.00	Cost of Drugs	9.00	21,161	0	21,161	0	0.000000	16.00
Cost Center Description	Part A	Program Visits		Part A	Part B	Ratio (col. 3 + col. 4)		
		Not Subject to Deductibles & Coinsurance	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	11,872		0	1,878,744	1.00
2.00	Physical Therapy	0	7,268		0	1,110,623	2.00
3.00	Occupational Therapy	0	1,079		0	178,585	3.00
4.00	Speech Pathology	0	540		0	89,375	4.00
5.00	Medical Social Services	0	84		0	65,042	5.00
6.00	Home Health Aide	0	2,383		0	237,657	6.00
7.00	Total (sum of lines 1-6)	0	23,226		0	3,560,026	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 140116	Period: From 07/01/2014	Worksheet H-3
				HHA CCN: 147455	To 06/30/2015	Part I Date/Time Prepared: 11/20/2015 1:32 pm
				Title XVII I	Home Health Agency I	PPS

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
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		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	0	0	0	0	0	15.00
16.00	Cost of Drugs		2,965	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of col.s. 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	1,878,744						1.00
2.00	Physical Therapy	1,110,623						2.00
3.00	Occupational Therapy	178,585						3.00
4.00	Speech Pathology	89,375						4.00
5.00	Medical Social Services	65,042						5.00
6.00	Home Health Aide	237,657						6.00
7.00	Total (sum of lines 1-6)	3,560,026						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140116

Period:

Worksheet H-3

HHA CCN: 147455

From 07/01/2014
To 06/30/2015

Part II
Date/Time Prepared:
11/20/2015 1:32 pm

Title XVIII

Home Health
Agency I

PPS

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	0.343243	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.333180	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.237841	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.458469	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.312720	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140116 HHA CCN: 147455	Period: From 07/01/2014 To 06/30/2015	Worksheet H-4 Part I-11 Date/Time Prepared: 11/20/2015 1:32 pm
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	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
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
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
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	3,378	0
			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	-3,378
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	3,849,476
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	123,217
13.00	Total PPS Reimbursement - LUPA Episodes		0	68,227
14.00	Total PPS Reimbursement - PEP Episodes		0	17,619
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	39,432
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	3,987
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	4,098,580
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	4,098,580
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	4,098,580
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	4,098,580
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
31.00	Subtotal (see instructions)		0	4,098,580
31.01	Sequestration adjustment (see instructions)		0	79,356
32.00	Interim payments (see instructions)		0	4,019,512
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	-288
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

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

Provider CCN: 140116
HHA CCN: 147455

Period:
From 07/01/2014
To 06/30/2015

Worksheet H-5
Date/Time Prepared:
11/20/2015 1:32 pm
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		4,019,512	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		4,019,512	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		288	6.02
7.00	Total Medicare program liability (see instructions)		0		4,019,224	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: 140116	Period: From 07/01/2014 To 06/30/2015	Worksheet L Parts I-III Date/Time Prepared: 11/20/2015 1:32 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,084,339	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		54,819	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)		97.96	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)		1.76	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		16.45	8.00
9.00	Sum of lines 7 and 8		18.21	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.76	10.00
11.00	Disproportionate share adjustment (see instructions)		115,971	11.00
12.00	Total prospective capital payments (see instructions)		3,255,129	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