

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: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet S Parts I-III Date/Time Prepared: 8/24/2015 1:08 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 8/24/2015 Time: 1:08 pm	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL OF CARBONDALE (140164) for the cost reporting period beginning 04/01/2014 and ending 03/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	692,661	212,886	26,271	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		-482		0	10.00
200.00 Total	0	692,661	212,404	26,271	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: 140164		Period: From 04/01/2014 To 03/31/2015		Worksheet S-2 Part I Date/Time Prepared: 8/24/2015 1:06 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 405 W. JACKSON ST.			PO Box:						1.00	
2.00	City: CARBONDALE			State: IL		Zip Code: 62901		County: JACKSON		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		MEMORIAL HOSPITAL OF CARBONDALE	140164	16060	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC		WEST FRANKFORT FAMILY MEDICINE	143454	99914		11/01/1999	N	O	N	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)						04/01/2014	03/31/2015		20.00	
21.00	Type of Control (see instructions)						2			21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						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.		9,623	21	0	0	156	1,425	24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		0	0	0	0	0		25.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet S-2 Part I Date/Time Prepared: 8/24/2015 1:06 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.	2				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1	10/01/2014			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 in effect in the cost reporting period.	0				37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for 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)(iii)? 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.	Y				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 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

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		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)					Y	63.00
				Unweighted FTEs Nonprovi der Site	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	Unweighted FTEs Nonprovi der Site	Unweighted 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)	SOUTHERN ILLINOIS FAMILY MEDICINE	1350	9.77	4.69	0.675657	65.00

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		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)	SOUTHERN ILLINOIS FAMILY MEDICINE	1350	10.52	5.46	0.658323 67.00
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N	70.00	
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N	75.00	
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)				0	76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00	

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		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: 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 would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				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, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	3,780,099	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140164		Period: From 04/01/2014 To 03/31/2015		Worksheet S-2 Part I Date/Time Prepared: 8/24/2015 1:06 pm	
		1.00	2.00				
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H124			140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 06101		141.00	
142.00	Street: 1239 E. MAIN	PO Box: 3988				142.00	
143.00	City: CARBONDALE	State: IL		Zip Code: 62902		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	N				145.00	
						1.00	
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, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	N	157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	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	
		Name		County		State	
		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 Section §1886(n)? Enter "Y" for yes or "N" for no.					Y	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet S-2 Part I Date/Time Prepared: 8/24/2015 1:06 pm	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07/01/2014	09/30/2014	170.00
				1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet S-2 Part II Date/Time Prepared: 8/24/2015 1:06 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	Y			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N	Legal Oper.		
		1.00	2.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	07/14/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet S-2 Part II Date/Time Prepared: 8/24/2015 1:06 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			Y	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.			Y	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			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			Y	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.				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.			Y	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.			Y	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUANNE	WARREN		41.00
42.00	Enter the employer/company name of the cost report preparer.	SOUTHERN ILLINOIS HOSPITAL SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6184575200	LUANNE.WARREN@SIH.NET		43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	07/14/2015		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT DIRECTOR		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

HFS Supplemental Information		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet S-2 Part IX Date/Time Prepared: 8/24/2015 1:06 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: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
8/24/2015 1:06 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	133	48,545	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	48,545	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	13	4,745	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 NEONATAL INTENSIVE CARE UNIT	35.00	13	4,745	0.00	0	12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		159	58,035	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		159				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)		9	3,285			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: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
8/24/2015 1:06 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	13,017	5,867	29,073			1.00
2.00 HMO and other (see instructions)	2,815	1,581				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	13,017	5,867	29,073			7.00
8.00 INTENSIVE CARE UNIT	1,709	542	3,854			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 NEONATAL INTENSIVE CARE UNIT	0	1,250	1,898			12.00
13.00 NURSERY		1,543	2,924			13.00
14.00 Total (see instructions)	14,726	9,202	37,749	12.88	1,078.47	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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	2,682	3,566	11,010	3.10	12.46	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				15.98	1,090.93	27.00
28.00 Observation Bed Days		1,160	3,983			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)	11	442	1,012			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			621			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
8/24/2015 1:06 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,897	2,561	10,516	1.00
2.00 HMO and other (see instructions)			713	594		2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						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 NEONATAL INTENSIVE CARE UNIT						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	3,897	2,561	10,516	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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	0.00					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: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet S-3 Part II Date/Time Prepared: 8/24/2015 1:06 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	59,564,679	0	59,564,679	2,269,140.18	26.25	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		456,674	0	456,674	26,959.24	16.94	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	1,023,997	0	1,023,997	39,096.00	26.19	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)		0	0	0	0.00	0.00	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		3,543,327	0	3,543,327	55,885.25	63.40	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		332,914	0	332,914	2,025.00	164.40	13.00
14.00	Home office salaries & wage-related costs		12,581,531	0	12,581,531	295,026.34	42.65	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		17,353,163	0	17,353,163			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		0	0	0			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		15,405	0	15,405			23.00
24.00	Wage-related costs (RHC/FQHC)		121,031	0	121,031			24.00
25.00	Interns & residents (in an approved program)		305,929	0	305,929			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	267,804	0	267,804	10,434.95	25.66	26.00
27.00	Administrative & General	5.00	3,705,414	0	3,705,414	113,244.63	32.72	27.00
28.00	Administrative & General under contract (see inst.)		153,767	0	153,767	705.96	217.81	28.00
29.00	Maintenance & Repairs	6.00	681,223	0	681,223	30,724.37	22.17	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	43,246	0	43,246	3,575.33	12.10	31.00
32.00	Housekeeping	9.00	1,067,745	0	1,067,745	86,427.56	12.35	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,400,868	-1,046,801	354,067	24,071.69	14.71	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,046,801	1,046,801	71,186.28	14.71	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,079,282	0	1,079,282	26,128.93	41.31	38.00
39.00	Central Services and Supply	14.00	346,486	0	346,486	24,410.56	14.19	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet S-3
Part II
Date/Time Prepared:
8/24/2015 1:06 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	16.00 530,644	0	530,644	34,123.34	15.55	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: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet S-3 Part III Date/Time Prepared: 8/24/2015 1:06 pm
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	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)	58,237,775	0	58,237,775	2,203,790.90	26.43	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	58,237,775	0	58,237,775	2,203,790.90	26.43	3.00
4.00	Subtotal other wages & related costs (see inst.)	16,457,772	0	16,457,772	352,936.59	46.63	4.00
5.00	Subtotal wage-related costs (see inst.)	17,353,163	0	17,353,163	0.00	29.80	5.00
6.00	Total (sum of lines 3 thru 5)	92,048,710	0	92,048,710	2,556,727.49	36.00	6.00
7.00	Total overhead cost (see instructions)	9,276,479	0	9,276,479	425,033.60	21.83	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet S-3 Part IV Date/Time Prepared: 8/24/2015 1:06 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,992,692	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		10,343,785	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		18,820	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		49,625	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)		181,218	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		683,029	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		4,264,296	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		66,568	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		195,495	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		17,795,528	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: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet S-3 Part V Date/Time Prepared: 8/24/2015 1:06 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	3,543,327	17,795,528	1.00
2.00	Hospital	3,543,327	17,674,497	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	121,031	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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2014 To 03/31/2015	Worksheet S-8 Date/Time Prepared: 8/24/2015 1:06 pm			
			Rural Health Clinic (RHC) I	Cost			
				1.00			
1.00	Clinic Address and Identification Street		2553 KEN GRAY BLVD	1.00			
		City	State	Zip Code			
		1.00	2.00	3.00			
2.00	City, State, Zip Code, County		WEST FRANKFORT IL	62896 2.00			
				1.00			
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00			
			Grant Award	Date			
			1.00	2.00			
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)			0 4.00			
5.00	Migrant Health Center (Section 329(d), PHS Act)			0 5.00			
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0 6.00			
7.00	Appalachian Regional Commission			0 7.00			
8.00	Look-Alikes			0 8.00			
9.00	OTHER (SPECIFY)			0 9.00			
				1.00 2.00			
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N 0 10.00			
		Sunday		Monday	Tuesday		
		from	to	from	to		
		1.00	2.00	3.00	4.00		
11.00	Facility hours of operations (1) Clinic		08:00	17:00	08:00 11.00		
				1.00 2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N 0 12.00			
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N 0 13.00			
			Provider name	CCN number			
			1.00	2.00			
14.00	Provider name, CCN number				14.00		
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		N	0	0	0 15.00	
			County				
			4.00				
2.00	City, State, Zip Code, County		FRANKLIN		2.00		
		Tuesday		Wednesday		Thursday	
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11.00	Facility hours of operations (1) Clinic		17:00	08:00	17:00	08:00	17:00 11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2014 To 03/31/2015	Worksheet S-8 Date/Time Prepared: 8/24/2015 1:06 pm
		Rural Health Clinic (RHC) I	Cost

	Friday		Saturday			
	from	to	from	to		
	11.00	11.00	12.00	13.00		
11.00	Facility hours of operations (1) Clinic		08:00	17:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet S-10 Date/Time Prepared: 8/24/2015 1:06 pm
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				1.00		
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.258605		1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		21,523,515		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		7,266,582		5.00	
6.00	Medicaid charges		162,214,964		6.00	
7.00	Medicaid cost (line 1 times line 6)		41,949,601		7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		13,159,504		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		305,645		18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		13,159,504		19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility		14,963,506	2,463,558	17,427,064	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		3,869,637	637,088	4,506,725	21.00
22.00	Partial payment by patients approved for charity care		0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		3,869,637	637,088	4,506,725	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?					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)				8,668,952	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)				1,219,670	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)				7,449,282	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)				1,926,422	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				6,433,147	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				19,592,651	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 140164		Period: From 04/01/2014 To 03/31/2015		Worksheet A		
Date/Time Prepared: 8/24/2015 1:06 pm								
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,512,179	4,512,179	359,994	4,872,173	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,189,526	5,189,526	168,365	5,357,891	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	267,804	22,710,267	22,978,071	0	22,978,071	4.00
5.01	00550	DATA PROCESSING	0	0	0	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	130,756	130,756	0	130,756	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	683,325	60,856	744,181	0	744,181	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	3,022,089	19,686,132	22,708,221	-12,753	22,695,468	5.04
6.00	00600	MAINTENANCE & REPAIRS	681,223	1,517,723	2,198,946	0	2,198,946	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,246	1,198,416	1,241,662	0	1,241,662	8.00
9.00	00900	HOUSEKEEPING	1,067,745	510,593	1,578,338	0	1,578,338	9.00
10.00	01000	DIETARY	1,400,868	1,167,708	2,568,576	-1,932,274	636,302	10.00
11.00	01100	CAFETERIA	0	0	0	1,919,373	1,919,373	11.00
13.00	01300	NURSING ADMINISTRATION	1,079,282	45,960	1,125,242	0	1,125,242	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	346,486	97,492	443,978	-19,714	424,264	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	530,644	88,358	619,002	0	619,002	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	2,393,519	2,393,519	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APRVD	1,023,997	0	1,023,997	0	1,023,997	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APRVD	0	1,077,085	1,077,085	0	1,077,085	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,298,531	6,853,787	20,152,318	-37,385	20,114,933	30.00
31.00	03100	INTENSIVE CARE UNIT	3,022,185	787,555	3,809,740	-53,589	3,756,151	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,270,709	634,791	1,905,500	-85	1,905,415	35.00
43.00	04300	NURSERY	8,033	160,498	168,531	-9,997	158,534	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,447,796	16,685,702	20,133,498	-9,665,617	10,467,881	50.00
50.01	05001	SAME DAY SURGERY	1,720,999	580,514	2,301,513	-2,301,513	0	50.01
51.00	05100	RECOVERY ROOM	691,505	46,234	737,739	-2,192	735,547	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,712,222	393,938	4,106,160	-18,821	4,087,339	52.00
53.00	05300	ANESTHESIOLOGY	40,952	3,075,132	3,116,084	-2,557,300	558,784	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,894,752	2,257,315	5,152,067	-906,907	4,245,160	54.00
54.01	03480	ONCOLOGY	937,886	1,638,270	2,576,156	5,452	2,581,608	54.01
54.02	03440	MAMMOGRAPHY	630,381	600,947	1,231,328	-59,696	1,171,632	54.02
56.00	05600	RADIOISOTOPE	326,286	1,097,365	1,423,651	235,843	1,659,494	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	219,319	205,580	424,899	-55,806	369,093	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,365,838	13,933,320	17,299,158	-8,097,522	9,201,636	59.00
60.00	06000	LABORATORY	2,311,163	4,699,302	7,010,465	-21,434	6,989,031	60.00
64.00	06400	INTRAVENOUS THERAPY	53,540	17,667	71,207	-1,748	69,459	64.00
65.00	06500	RESPIRATORY THERAPY	1,355,852	505,114	1,860,966	-114,272	1,746,694	65.00
66.00	06600	PHYSICAL THERAPY	2,127,481	685,337	2,812,818	-95	2,812,723	66.00
69.00	06900	ELECTROCARDIOLOGY	1,141,558	6,755,814	7,897,372	-461,201	7,436,171	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	96,593	130,579	227,172	-17,667	209,505	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,824,237	9,824,237	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,453,918	11,453,918	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,823,417	6,343,349	9,166,766	546,338	9,713,104	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	405,111	1,033,263	1,438,374	-16,787	1,421,587	88.00
91.00	09100	EMERGENCY	3,515,861	3,509,950	7,025,811	-14,305	7,011,506	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		4,849,826	4,849,826	-528,359	4,321,467	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	59,564,679	135,474,200	195,038,879	0	195,038,879	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	151,214	151,214	0	151,214	192.00
192.01	19201	FAMILY PRACTICE	0	0	0	0	0	192.01
192.02	19202	UNUSED SPACE	0	0	0	0	0	192.02
200.00		TOTAL (SUM OF LINES 118-199)	59,564,679	135,625,414	195,190,093	0	195,190,093	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet A
Date/Time Prepared:
8/24/2015 1:06 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	-19,742	4,852,431	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,606,298	10,964,189	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	539,700	23,517,771	4.00
5.01	00550	DATA PROCESSING	5,989,544	5,989,544	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-14,289	116,467	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,380,692	4,124,873	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	-5,108,181	17,587,287	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	2,198,946	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,241,662	8.00
9.00	00900	HOUSEKEEPING	-119	1,578,219	9.00
10.00	01000	DIETARY	0	636,302	10.00
11.00	01100	CAFETERIA	-1,007,928	911,445	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,125,242	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	424,264	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-116,390	502,612	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-2,393,519	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,023,997	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	-893	1,076,192	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,604,457	17,510,476	30.00
31.00	03100	INTENSIVE CARE UNIT	-19,325	3,736,826	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-566,313	1,339,102	35.00
43.00	04300	NURSERY	0	158,534	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-260,416	10,207,465	50.00
50.01	05001	SAME DAY SURGERY	0	0	50.01
51.00	05100	RECOVERY ROOM	0	735,547	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,087,339	52.00
53.00	05300	ANESTHESIOLOGY	0	558,784	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-9,863	4,235,297	54.00
54.01	03480	ONCOLOGY	-728,765	1,852,843	54.01
54.02	03440	MAMMOGRAPHY	-48,630	1,123,002	54.02
56.00	05600	RADIOISOTOPE	0	1,659,494	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	369,093	58.00
59.00	05900	CARDIAC CATHETERIZATION	-36,739	9,164,897	59.00
60.00	06000	LABORATORY	-118,363	6,870,668	60.00
64.00	06400	INTRAVENOUS THERAPY	0	69,459	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,746,694	65.00
66.00	06600	PHYSICAL THERAPY	-66,848	2,745,875	66.00
69.00	06900	ELECTROCARDIOLOGY	-213,753	7,222,418	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-8,900	200,605	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,824,237	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,453,918	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,713,104	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-38,088	1,383,499	88.00
91.00	09100	EMERGENCY	-2,655,272	4,356,234	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-4,321,467	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,842,026	190,196,853	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	151,214	192.00
192.01	19201	FAMILY PRACTICE	0	0	192.01
192.02	19202	UNUSED SPACE	0	0	192.02
200.00		TOTAL (SUM OF LINES 118-199)	-4,842,026	190,348,067	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet Non-CMS W
Date/Time Prepared:
8/24/2015 1:06 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
5.01	DATA PROCESSING	00550	DATA PROCESSING	5.01
5.02	PURCHASING RECEIVING AND STORES	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	00590		5.04
6.00	MAINTENANCE & REPAIRS	00600		6.00
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
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	02100		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	02200		22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
35.00	NEONATAL INTENSIVE CARE UNIT	02060	NEONATAL INTENSIVE CARE UNIT	35.00
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
50.01	SAME DAY SURGERY	05001		50.01
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
54.01	ONCOLOGY	03480	ONCOLOGY	54.01
54.02	MAMMOGRAPHY	03440	MAMMOGRAPHY	54.02
56.00	RADIOLOGY	05600		56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
64.00	INTRAVENOUS THERAPY	06400		64.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	08800		88.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
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
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	FAMILY PRACTICE	19201		192.01
192.02	UNUSED SPACE	19202		192.02
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet A-6
Date/Time Prepared:
8/24/2015 1:06 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - DIETARY RECLASS						
1.00	CAFETERIA	11.00	1,046,801	872,572	1.00	
	TOTALS		1,046,801	872,572		
B - NUTRITIONAL PRODUCT RECLASS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	110,361	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
	TOTALS		0	110,361		
C - MEDICAL SUPPLY RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	21,278,155	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
	TOTALS		0	21,278,155		
D - SAME DAY SURGERY RECLASS						
1.00	OPERATING ROOM	50.00	1,720,999	580,514	1.00	
	TOTALS		1,720,999	580,514		
E - INTEREST RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	359,994	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	168,365	2.00	
	TOTALS		0	528,359		
F - IMPLANTABLE DEVICE RECLASS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	11,453,918	1.00	
	TOTALS		0	11,453,918		
G - CRNA RECLASS						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	2,393,519	1.00	
	TOTALS		0	2,393,519		
H - CONTRAST DRUG RECLASS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	435,977	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
	TOTALS		0	435,977		
I - ISOTOPE RECLASS						
1.00	RADIOISOTOPE	56.00	0	235,896	1.00	
	TOTALS		0	235,896		
J - CANCER CENTER MED DIRECTOR RECLASS						
1.00	ONCOLOGY	54.01	0	11,762	1.00	
	TOTALS		0	11,762		
500.00	Grand Total: Increases		2,767,800	37,901,033	500.00	

RECLASSIFICATIONS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet A-6
Date/Time Prepared:
8/24/2015 1:06 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - DIETARY RECLASS							
1.00	DIETARY	10.00	1,046,801	872,572	0		1.00
	TOTALS		1,046,801	872,572			
B - NUTRITIONAL PRODUCT RECLASS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	309	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	30,925	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	8,268	0		3.00
4.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	85	0		4.00
5.00	NURSERY	43.00	0	9,936	0		5.00
6.00	OPERATING ROOM	50.00	0	9,853	0		6.00
7.00	RECOVERY ROOM	51.00	0	2,192	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	8,522	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	11,172	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	891	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	5,616	0		11.00
12.00	RADIOISOTOPE	56.00	0	53	0		12.00
13.00	LABORATORY	60.00	0	46	0		13.00
14.00	INTRAVENOUS THERAPY	64.00	0	78	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	904	0		15.00
16.00	EMERGENCY	91.00	0	8,422	0		16.00
17.00	MAMMOGRAPHY	54.02	0	188	0		17.00
18.00	DIETARY	10.00	0	12,901	0		18.00
	TOTALS		0	110,361			
C - MEDICAL SUPPLY RECLASS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	19,405	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	6,460	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	45,321	0		3.00
4.00	NURSERY	43.00	0	61	0		4.00
5.00	OPERATING ROOM	50.00	0	11,957,277	0		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	10,299	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	152,609	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	863,271	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	2,950	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	7,975,114	0		10.00
11.00	LABORATORY	60.00	0	21,388	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	114,272	0		12.00
13.00	EMERGENCY	91.00	0	5,883	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	817	0		14.00
15.00	ELECTROENCEPHALOGRAPHY	70.00	0	17,667	0		15.00
16.00	MAMMOGRAPHY	54.02	0	59,508	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	95	0		17.00
18.00	ONCOLOGY	54.01	0	6,310	0		18.00
19.00	RURAL HEALTH CLINIC	88.00	0	16,787	0		19.00
20.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	991	0		20.00
21.00	INTRAVENOUS THERAPY	64.00	0	1,670	0		21.00
	TOTALS		0	21,278,155			
D - SAME DAY SURGERY RECLASS							
1.00	SAME DAY SURGERY	50.01	1,720,999	580,514	0		1.00
	TOTALS		1,720,999	580,514			
E - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	528,359	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	528,359			
F - IMPLANTABLE DEVICE RECLASS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	11,453,918	0		1.00
	TOTALS		0	11,453,918			
G - CRNA RECLASS							
1.00	ANESTHESIOLOGY	53.00	0	2,393,519	0		1.00
	TOTALS		0	2,393,519			
H - CONTRAST DRUG RECLASS							
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	52,856	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	223,584	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	42,745	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	116,792	0		4.00
	TOTALS		0	435,977			
I - ISOTOPE RECLASS							
1.00	ELECTROCARDIOLOGY	69.00	0	235,896	0		1.00
	TOTALS		0	235,896			

RECLASSIFICATIONS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet A-6

Date/Time Prepared:
8/24/2015 1:06 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
J - CANCER CENTER MED DIRECTOR RECLASS							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	11,762	0	1.00	
	TOTALS		0	11,762			
500.00	Grand Total: Decreases		2,767,800	37,901,033		500.00	

RECLASSIFICATIONS

Provider CCN: 140164

Period: From 04/01/2014 To 03/31/2015

Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 8/24/2015 1:06 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 - DIETARY RECLASS									
1.00	CAFETERIA	11.00	1,046,801	872,572	DIETARY	10.00	1,046,801	872,572	1.00
	TOTALS		1,046,801	872,572	TOTALS		1,046,801	872,572	
B - NUTRITIONAL PRODUCT RECLASS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	110,361	CENTRAL SERVICES & SUPPLY	14.00	0	309	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	30,925	2.00
3.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	8,268	3.00
4.00		0.00	0	0	NEONATAL INTENSIVE CARE UNIT	35.00	0	85	4.00
5.00		0.00	0	0	NURSERY	43.00	0	9,936	5.00
6.00		0.00	0	0	OPERATING ROOM	50.00	0	9,853	6.00
7.00		0.00	0	0	RECOVERY ROOM	51.00	0	2,192	7.00
8.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	8,522	8.00
9.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	11,172	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	891	10.00
11.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	5,616	11.00
12.00		0.00	0	0	RADIOISOTOPE	56.00	0	53	12.00
13.00		0.00	0	0	LABORATORY	60.00	0	46	13.00
14.00		0.00	0	0	INTRAVENOUS THERAPY	64.00	0	78	14.00
15.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	904	15.00
16.00		0.00	0	0	EMERGENCY	91.00	0	8,422	16.00
17.00		0.00	0	0	MAMMOGRAPHY	54.02	0	188	17.00
18.00		0.00	0	0	DIETARY	10.00	0	12,901	18.00
	TOTALS		0	110,361	TOTALS		0	110,361	
C - MEDICAL SUPPLY RECLASS									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	21,278,155	CENTRAL SERVICES & SUPPLY	14.00	0	19,405	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	6,460	2.00
3.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	45,321	3.00
4.00		0.00	0	0	NURSERY	43.00	0	61	4.00
5.00		0.00	0	0	OPERATING ROOM	50.00	0	11,957,277	5.00
6.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	10,299	6.00
7.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	152,609	7.00
8.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	863,271	8.00
9.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	2,950	9.00
10.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	7,975,114	10.00
11.00		0.00	0	0	LABORATORY	60.00	0	21,388	11.00
12.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	114,272	12.00
13.00		0.00	0	0	EMERGENCY	91.00	0	5,883	13.00
14.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	817	14.00
15.00		0.00	0	0	ELECTROENCEPHALOGRAPHY	70.00	0	17,667	15.00
16.00		0.00	0	0	MAMMOGRAPHY	54.02	0	59,508	16.00
17.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	95	17.00
18.00		0.00	0	0	ONCOLOGY	54.01	0	6,310	18.00
19.00		0.00	0	0	RURAL HEALTH CLINIC	88.00	0	16,787	19.00
20.00		0.00	0	0	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	991	20.00
21.00		0.00	0	0	INTRAVENOUS THERAPY	64.00	0	1,670	21.00
	TOTALS		0	21,278,155	TOTALS		0	21,278,155	
D - SAME DAY SURGERY RECLASS									
1.00	OPERATING ROOM	50.00	1,720,999	580,514	SAME DAY SURGERY	50.01	1,720,999	580,514	1.00
	TOTALS		1,720,999	580,514	TOTALS		1,720,999	580,514	
E - INTEREST RECLASS									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	359,994	INTEREST EXPENSE	113.00	0	528,359	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	168,365		0.00	0	0	2.00
	TOTALS		0	528,359	TOTALS		0	528,359	
F - IMPLANTABLE DEVICE RECLASS									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	11,453,918	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	11,453,918	1.00
	TOTALS		0	11,453,918	TOTALS		0	11,453,918	
G - CRNA RECLASS									
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	2,393,519	ANESTHESIOLOGY	53.00	0	2,393,519	1.00
	TOTALS		0	2,393,519	TOTALS		0	2,393,519	

RECLASSIFICATIONS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
8/24/2015 1:06 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		
H - CONTRAST DRUG RECLASS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	435,977	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	52,856	1.00
2.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	223,584	2.00
3.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	42,745	3.00
4.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	116,792	4.00
TOTALS			0	435,977	TOTALS		0	435,977	
I - ISOTOPE RECLASS									
1.00	RADIOISOTOPE	56.00	0	235,896	ELECTROCARDIOLOGY	69.00	0	235,896	1.00
TOTALS			0	235,896	TOTALS		0	235,896	
J - CANCER CENTER MED DIRECTOR RECLASS									
1.00	ONCOLOGY	54.01	0	11,762	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	11,762	1.00
TOTALS			0	11,762	TOTALS		0	11,762	
500.00	Grand Total: Increases		2,767,800	37,901,033	Grand Total: Decreases		2,767,800	37,901,033	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet A-7
Part I
Date/Time Prepared:
8/24/2015 1:06 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	5,937,499	20,000	0	20,000	0	1.00
2.00	Land Improvements	3,264,065	1,940,505	0	1,940,505	2,070	2.00
3.00	Buildings and Fixtures	105,854,086	24,517,217	0	24,517,217	11,197	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	58,326,178	12,811,891	0	12,811,891	7,521,571	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	173,381,828	39,289,613	0	39,289,613	7,534,838	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	173,381,828	39,289,613	0	39,289,613	7,534,838	10.00
	Ending Balance		Fully Depreciated Assets				
	6.00		7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,957,499	0				1.00
2.00	Land Improvements	5,202,500	0				2.00
3.00	Buildings and Fixtures	130,360,106	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	63,616,498	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	205,136,603	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	205,136,603	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet A-7
Part II
Date/Time Prepared:
8/24/2015 1:06 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	4,512,179	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,189,526	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,701,705	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	4,512,179				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,189,526				2.00
3.00	Total (sum of lines 1-2)	0	9,701,705				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet A-7
Part III
Date/Time Prepared:
8/24/2015 1:06 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	80,869,061	0	80,869,061	0.394221	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	124,267,543	0	124,267,543	0.605779	0	2.00
3.00	Total (sum of lines 1-2)	205,136,604	0	205,136,604	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	4,852,431	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	10,964,189	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	15,816,620	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	0	0	0	0	4,852,431	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	10,964,189	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	15,816,620	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 #		
			3.00	4.00		
1.00	2.00	3.00	4.00	5.00		
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0 2.00
3.00 Investment income - other (chapter 2)			0		0.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0 4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0 5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0 7.00
8.00 Television and radio service (chapter 21)			0		0.00	0 8.00
9.00 Parking lot (chapter 21)			0		0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-7,300,769				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	29,979,338				0 12.00
13.00 Laundry and linen service			0		0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-989,183	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	-88,373	MEDICAL RECORDS & LIBRARY		16.00	0 18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0 19.00
20.00 Vending machines	B	-18,745	CAFETERIA		11.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			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	A	-2,393,519	NONPHYSICIAN ANESTHETISTS		19.00	28.00
29.00 Physicians' assistant			0		0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00	30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0 32.00
33.00 EMPLOYEE OUTPATIENT PAYMENTS	B	-4,563,604	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.00

Provider CCN: 140164
Period: From 04/01/2014 To 03/31/2015
Worksheet A-8
Date/Time Prepared: 8/24/2015 1:06 pm

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
				Cost Center	Line #	
		1.00	2.00	3.00	4.00	5.00
33.01	DEBT FORGIVENESS	A	-7,369,798	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 33.01
33.02	TELEVISION AND RADIO SERVICES	A	-3,248	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.02
33.03	INTEREST INCOME UNRESTRICTED	B	-1,636,723	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 33.03
33.04	LOSS ON 1994 BONDS	A	147,198	CAP REL COSTS-BLDG & FIXT	1.00	9 33.04
33.05	LOSS ON 1994 BONDS	A	126,252	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.05
33.06	FUNDED DEPRECIATION	A	-6,883	CAP REL COSTS-BLDG & FIXT	1.00	9 33.06
33.07	NONALLOWABLE BOND EXPENSE	B	-4,321,467	INTEREST EXPENSE	113.00	0 33.07
33.08	MISCELLANEOUS INCOME	B	-17,390	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 33.08
33.09	SALE OF XRAY SILVER/FILM	B	-3,719	RADIOLOGY-DIAGNOSTIC	54.00	0 33.09
33.10	OFFSET LOBBYING EXPENSES	A	-31,618	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 33.10
33.11	PURCHASE DISCOUNT	B	-14,289	PURCHASING RECEIVING AND STORES	5.02	0 33.11
33.12	LOSS ON 1987 BONDS	A	70,029	CAP REL COSTS-BLDG & FIXT	1.00	9 33.12
33.13	LOSS ON 1987 BONDS	A	24,248	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.13
33.14	LOSS ON 1991 BONDS	A	189,354	CAP REL COSTS-BLDG & FIXT	1.00	9 33.14
33.15	LOSS ON 1991 BONDS	A	129,585	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.15
33.16	LEASEHOLD REVENUE	B	-36,174	MAMMOGRAPHY	54.02	0 33.16
33.17	VENDING MACHINE INCOME	B	-119	HOUSEKEEPING	9.00	0 33.17
33.18	PATIENT'S GUEST LODGING EXPENSE	A	-23,438	CARDIAC CATHETERIZATION	59.00	0 33.18
33.19	LEASEHOLD REVENUE	B	-524,731	CAP REL COSTS-BLDG & FIXT	1.00	9 33.19
33.20	MEDI CAID PROVIDER TAX	A	-6,116,079	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 33.20
33.21	CABLE TV	A	-893	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0 33.21
33.22	PERSONAL PORTION OF PROVIDER VEHICLE	A	-8,063	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 33.22
33.23	SALE OF MEDICAL RECORDS AND ABSTRACT	B	-1,040	RURAL HEALTH CLINIC	88.00	0 33.23
33.24	MISCELLANEOUS INCOME	B	-36,386	RURAL HEALTH CLINIC	88.00	0 33.24
33.25	INTEREST INCOME UNRESTRICTED	B	-662	RURAL HEALTH CLINIC	88.00	0 33.25
33.26	VENDING MACHINE INCOME	B	-1,117	ELECTROCARDIOLOGY	69.00	0 33.26
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,842,026			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: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet A-8-1

Date/Time Prepared:
8/24/2015 1:06 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	105,291	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	5,329,461	0
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	5,103,304	0
4.00	5.01	DATA PROCESSING	HOME OFFICE	5,989,544	0
4.01	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	3,380,692	0
4.02	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	10,195,560	0
4.03	66.00	PHYSICAL THERAPY	RENT	78,376	145,224
4.04	5.04	OTHER ADMINISTRATIVE AND GEN	RENT	14,550	29,520
4.05	16.00	MEDICAL RECORDS & LIBRARY	RENT	23,211	51,228
4.06	54.00	RADIOLOGY-DIAGNOSTIC	RENT	5,328	11,472
4.07	60.00	LABORATORY	RENT	1,233	9,768
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			30,226,550	247,212

* 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	SIHS	100.00	SIHS	100.00	6.00
7.00	B	SIHE	100.00	SIHE	100.00	7.00
8.00	B	HSSI	100.00	SIHE	100.00	8.00
9.00	B	SIMS	100.00	SIHE	100.00	9.00
10.00	B	SIH CAYMAN SPC	100.00	SIH CAYMAN	100.00	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: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet A-8-1

Date/Time Prepared:
8/24/2015 1:06 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	105,291	9		1.00
2.00	5,329,461	9		2.00
3.00	5,103,304	0		3.00
4.00	5,989,544	0		4.00
4.01	3,380,692	0		4.01
4.02	10,195,560	0		4.02
4.03	-66,848	0		4.03
4.04	-14,970	0		4.04
4.05	-28,017	0		4.05
4.06	-6,144	0		4.06
4.07	-8,535	0		4.07
5.00	29,979,338			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	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
10.00	CAPTIVE		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: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet A-8-2

Date/Time Prepared:
8/24/2015 1:06 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	DR. A	2,604,457	2,604,457	0	0	0	1.00
2.00	31.00	DR. B	48,750	0	48,750	159,800	383	2.00
3.00	35.00	DR. C	584,444	537,244	47,200	159,800	236	3.00
4.00	50.00	DR. D	260,416	260,416	0	182,900	0	4.00
5.00	54.02	DR. E	34,948	0	34,948	217,600	215	5.00
6.00	59.00	DR. F	28,784	0	28,784	217,600	148	6.00
7.00	60.00	DR. G	109,828	109,828	0	208,000	0	7.00
8.00	54.01	DR. H	811,202	674,386	136,816	217,600	788	8.00
9.00	69.00	DR. I	212,636	212,636	0	0	0	9.00
10.00	70.00	DR. J	8,900	8,900	0	0	0	10.00
11.00	91.00	DR. K	2,666,796	2,646,130	20,666	159,800	150	11.00
12.00	5.04	DR. L	117,167	101,417	15,750	159,800	105	12.00
200.00			7,488,328	7,155,414	332,914		2,025	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	DR. A	0	0	0	0	0	1.00
2.00	31.00	DR. B	29,425	1,471	0	0	0	2.00
3.00	35.00	DR. C	18,131	907	0	0	0	3.00
4.00	50.00	DR. D	0	0	0	0	0	4.00
5.00	54.02	DR. E	22,492	1,125	0	0	0	5.00
6.00	59.00	DR. F	15,483	774	0	0	0	6.00
7.00	60.00	DR. G	0	0	0	0	0	7.00
8.00	54.01	DR. H	82,437	4,122	0	0	0	8.00
9.00	69.00	DR. I	0	0	0	0	0	9.00
10.00	70.00	DR. J	0	0	0	0	0	10.00
11.00	91.00	DR. K	11,524	576	0	0	0	11.00
12.00	5.04	DR. L	8,067	403	0	0	0	12.00
200.00			187,559	9,378	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	DR. A	0	0	0	2,604,457	1.00
2.00	31.00	DR. B	0	29,425	19,325	19,325	2.00
3.00	35.00	DR. C	0	18,131	29,069	566,313	3.00
4.00	50.00	DR. D	0	0	0	260,416	4.00
5.00	54.02	DR. E	0	22,492	12,456	12,456	5.00
6.00	59.00	DR. F	0	15,483	13,301	13,301	6.00
7.00	60.00	DR. G	0	0	0	109,828	7.00
8.00	54.01	DR. H	0	82,437	54,379	728,765	8.00
9.00	69.00	DR. I	0	0	0	212,636	9.00
10.00	70.00	DR. J	0	0	0	8,900	10.00
11.00	91.00	DR. K	0	11,524	9,142	2,655,272	11.00
12.00	5.04	DR. L	0	8,067	7,683	109,100	12.00
200.00			0	187,559	145,355	7,300,769	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet B
Part I
Date/Time Prepared:
8/24/2015 1:06 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,852,431	4,852,431			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	10,964,189		10,964,189		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	23,517,771	18,151	6,465	23,542,387	4.00
5.01 00550	DATA PROCESSING	5,989,544	24,145	0	0	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	116,467	51,614	32,334	0	5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	4,124,873	50,829	1,703	271,298	5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	17,587,287	980,078	182,138	1,199,848	5.04
6.00 00600	MAINTENANCE & REPAIRS	2,198,946	650,107	10,342	270,463	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,241,662	16,331	0	17,170	8.00
9.00 00900	HOUSEKEEPING	1,578,219	38,239	4,678	423,923	9.00
10.00 01000	DIETARY	636,302	73,388	42,690	140,574	10.00
11.00 01100	CAFETERIA	911,445	82,388	169	415,607	11.00
13.00 01300	NURSING ADMINISTRATION	1,125,242	69,230	317,959	428,503	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	424,264	50,078	115,819	137,564	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	502,612	0	7,644	210,679	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,023,997	0	0	406,553	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,076,192	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	17,510,476	1,074,187	474,072	5,279,848	30.00
31.00 03100	INTENSIVE CARE UNIT	3,736,826	117,104	185,922	1,199,886	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	1,339,102	31,025	119,284	504,505	35.00
43.00 04300	NURSERY	158,534	15,262	8,326	3,189	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	10,207,465	339,355	2,077,902	2,052,146	50.00
50.01 05001	SAME DAY SURGERY	0	0	0	0	50.01
51.00 05100	RECOVERY ROOM	735,547	64,071	71,041	274,545	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,087,339	154,173	129,643	1,473,849	52.00
53.00 05300	ANESTHESIOLOGY	558,784	6,996	131,227	16,259	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,235,297	145,507	1,691,164	1,149,292	54.00
54.01 03480	ONCOLOGY	1,852,843	115,718	1,264,681	372,365	54.01
54.02 03440	MAMMOGRAPHY	1,123,002	0	368,164	250,278	54.02
56.00 05600	RADIOISOTOPE	1,659,494	30,006	155,458	129,544	56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	369,093	21,056	943,501	87,075	58.00
59.00 05900	CARDIAC CATHETERIZATION	9,164,897	215,088	1,191,407	1,336,325	59.00
60.00 06000	LABORATORY	6,870,668	96,749	374,718	917,592	60.00
64.00 06400	INTRAVENOUS THERAPY	69,459	6,312	0	21,257	64.00
65.00 06500	RESPIRATORY THERAPY	1,746,694	20,906	86,773	538,308	65.00
66.00 06600	PHYSICAL THERAPY	2,745,875	2,405	35,433	844,665	66.00
69.00 06900	ELECTROCARDIOLOGY	7,222,418	37,437	445,267	453,228	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	200,605	13,442	73,336	38,350	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,824,237	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	11,453,918	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	9,713,104	32,344	34,920	1,120,970	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	1,383,499	0	11,929	160,840	88.00
91.00 09100	EMERGENCY	4,356,234	151,652	365,705	1,395,889	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	190,196,853	4,795,373	10,961,814	23,542,387	6,013,689
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,002	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	151,214	20,572	2,375	0	192.00
192.01 19201	FAMILY PRACTICE	0	2,789	0	0	192.01
192.02 19202	UNUSED SPACE	0	32,695	0	0	192.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	190,348,067	4,852,431	10,964,189	23,542,387	6,013,689

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet B
Part I
Date/Time Prepared:
8/24/2015 1:06 pm

Cost Center Description			PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
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
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	206,539					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	456	4,577,761				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	9	0	20,420,902	20,420,902		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	3,258,460	391,582	3,650,042	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	53	0	1,275,216	153,248	19,369	8.00
9.00	00900	HOUSEKEEPING	40	0	2,069,595	248,712	45,352	9.00
10.00	01000	DIETARY	45	0	966,486	116,146	87,041	10.00
11.00	01100	CAFETERIA	133	0	1,409,742	169,414	97,716	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,002,173	240,609	82,110	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	491	0	752,712	90,456	59,394	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	861,785	103,564	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,430,550	171,915	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	1,076,192	129,330	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,133	252,462	26,000,060	3,124,608	1,274,029	30.00
31.00	03100	INTENSIVE CARE UNIT	10,513	33,673	5,498,261	660,748	138,889	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	412	51,060	2,088,255	250,954	36,797	35.00
43.00	04300	NURSERY	2,569	10,907	211,035	25,361	18,101	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	95,122	665,444	15,976,339	1,919,941	402,488	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	534	64,584	1,283,809	154,280	75,990	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,955	47,628	6,044,561	726,399	182,856	52.00
53.00	05300	ANESTHESIOLOGY	10,628	92,620	822,638	98,860	8,298	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,340	563,697	8,028,006	964,758	172,577	54.00
54.01	03480	ONCOLOGY	14	197,791	3,993,254	479,885	137,246	54.01
54.02	03440	MAMMOGRAPHY	267	47,555	2,003,603	240,781	0	54.02
56.00	05600	RADIOISOTOPE	224	96,924	2,102,270	252,638	35,589	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	178	108,796	1,535,823	184,566	24,974	58.00
59.00	05900	CARDIAC CATHETERIZATION	21,679	257,554	12,560,509	1,509,447	255,103	59.00
60.00	06000	LABORATORY	3,428	479,477	8,987,589	1,080,075	114,748	60.00
64.00	06400	INTRAVENOUS THERAPY	221	22	109,519	13,161	7,486	64.00
65.00	06500	RESPIRATORY THERAPY	2,047	68,758	2,512,477	301,934	24,795	65.00
66.00	06600	PHYSICAL THERAPY	588	90,980	4,069,009	488,989	2,852	66.00
69.00	06900	ELECTROCARDIOLOGY	1,004	300,962	8,601,166	1,033,637	44,402	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	19	5,832	343,832	41,320	15,943	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	262,405	10,086,642	1,212,152	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	321,644	11,775,562	1,415,116	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	284	323,983	11,354,207	1,364,480	38,361	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	174	7,981	1,821,628	218,912	0	88.00
91.00	09100	EMERGENCY	8,979	225,022	6,803,553	817,610	179,865	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	206,539	4,577,761	190,137,420	20,395,588	3,582,371	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,002	120	1,188	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	174,161	20,930	24,399	192.00
192.01	19201	FAMILY PRACTICE	0	0	2,789	335	3,307	192.01
192.02	19202	UNUSED SPACE	0	0	32,695	3,929	38,777	192.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers			0			201.00
202.00		TOTAL (sum lines 118-201)	206,539	4,577,761	190,348,067	20,420,902	3,650,042	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet B Part I Date/Time Prepared: 8/24/2015 1:06 pm
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
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
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,447,833				8.00
9.00	00900	HOUSEKEEPING	0	2,363,659			9.00
10.00	01000	DIETARY	0	57,383	1,227,056		10.00
11.00	01100	CAFETERIA	0	64,420	0	1,741,292	11.00
13.00	01300	NURSING ADMINISTRATION	0	54,132	0	21,330	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	39,156	0	23,269	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	31,025	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	36,842	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,208,697	839,917	1,024,385	463,441	983,675
31.00	03100	INTENSIVE CARE UNIT	160,228	91,564	135,795	85,319	178,974
35.00	02060	NEONATAL INTENSIVE CARE UNIT	78,908	24,259	66,876	34,903	75,398
43.00	04300	NURSERY	0	11,934	0	0	537
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	265,345	0	184,212	388,242
50.01	05001	SAME DAY SURGERY	0	0	0	0	0
51.00	05100	RECOVERY ROOM	0	50,097	0	15,513	34,621
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	120,549	0	118,284	249,843
53.00	05300	ANESTHESIOLOGY	0	5,471	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	113,773	0	89,198	0
54.01	03480	ONCOLOGY	0	90,481	0	29,086	0
54.02	03440	MAMMOGRAPHY	0	0	0	29,086	0
56.00	05600	RADIOISOTOPE	0	23,462	0	7,756	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	16,464	0	7,756	0
59.00	05900	CARDIAC CATHETERIZATION	0	168,179	0	98,893	210,226
60.00	06000	LABORATORY	0	75,649	0	98,893	0
64.00	06400	INTRAVENOUS THERAPY	0	4,935	0	1,939	0
65.00	06500	RESPIRATORY THERAPY	0	16,347	0	48,477	12,286
66.00	06600	PHYSICAL THERAPY	0	1,880	0	65,929	0
69.00	06900	ELECTROCARDIOLOGY	0	29,272	0	42,660	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,510	0	3,878	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,290	0	54,294	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	23,269	0
91.00	09100	EMERGENCY	0	118,578	0	126,040	266,552
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,447,833	2,319,047	1,227,056	1,741,292	2,400,354
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	783	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	16,085	0	0	0
192.01	19201	FAMILY PRACTICE	0	2,180	0	0	0
192.02	19202	UNUSED SPACE	0	25,564	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,447,833	2,363,659	1,227,056	1,741,292	2,400,354

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet B
Part I
Date/Time Prepared:
8/24/2015 1:06 pm

Cost Center Description	INTERNS & RESIDENTS						
	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
	14.00	16.00	19.00	21.00	22.00		
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	
5.01 00550	DATA PROCESSING					5.01	
5.02 00560	PURCHASING RECEIVING AND STORES					5.02	
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03	
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL					5.04	
6.00 00600	MAINTENANCE & REPAIRS					6.00	
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	964,987				14.00	
16.00 01600	MEDICAL RECORDS & LIBRARY	0	996,374			16.00	
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00	
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,602,465		21.00	
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	1,242,364	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	305	54,943		229,707	178,088	30.00
31.00 03100	INTENSIVE CARE UNIT	1,924	7,328		0	0	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	11,112		0	0	35.00
43.00 04300	NURSERY	3	2,374		0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	524,875	144,943	0	50,889	39,454	50.00
50.01 05001	SAME DAY SURGERY	0	0	0	0	0	50.01
51.00 05100	RECOVERY ROOM	0	14,055	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	487	10,365	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	7,214	20,157	0	5,396	4,183	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	40,643	122,676	0	15,206	11,789	54.00
54.01 03480	ONCOLOGY	298	43,045	0	0	0	54.01
54.02 03440	MAMMOGRAPHY	2,813	10,349	0	0	0	54.02
56.00 05600	RADIOISOTOPE	0	21,093	0	0	0	56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	139	23,677	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	376,953	56,051	0	0	0	59.00
60.00 06000	LABORATORY	1,011	104,348	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	79	5	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	5,402	14,964	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	4	19,800	0	33,139	25,692	66.00
69.00 06900	ELECTROCARDIOLOGY	39	65,498	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	835	1,269	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	897	57,107	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	69,999	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	70,508	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	794	1,737	0	277,071	214,809	88.00
91.00 09100	EMERGENCY	272	48,971	0	49,050	38,028	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	964,987	996,374	0	660,458	512,043	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201	FAMILY PRACTICE	0	0	0	942,007	730,321	192.01
192.02 19202	UNUSED SPACE	0	0	0	0	0	192.02
200.00	Cross Foot Adjustments			0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	964,987	996,374	0	1,602,465	1,242,364	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet B
Part I
Date/Time Prepared:
8/24/2015 1:06 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
5.01	00550	DATA PROCESSING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,381,855	-407,795	34,974,060	30.00
31.00	03100	INTENSIVE CARE UNIT	6,959,030	0	6,959,030	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,667,462	0	2,667,462	35.00
43.00	04300	NURSERY	269,345	0	269,345	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,896,728	-90,343	19,806,385	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	50.01
51.00	05100	RECOVERY ROOM	1,628,365	0	1,628,365	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,453,344	0	7,453,344	52.00
53.00	05300	ANESTHESIOLOGY	972,217	-9,579	962,638	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,558,626	-26,995	9,531,631	54.00
54.01	03480	ONCOLOGY	4,773,295	0	4,773,295	54.01
54.02	03440	MAMMOGRAPHY	2,286,632	0	2,286,632	54.02
56.00	05600	RADIOISOTOPE	2,442,808	0	2,442,808	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,793,399	0	1,793,399	58.00
59.00	05900	CARDIAC CATHETERIZATION	15,235,361	0	15,235,361	59.00
60.00	06000	LABORATORY	10,462,313	0	10,462,313	60.00
64.00	06400	INTRAVENOUS THERAPY	137,124	0	137,124	64.00
65.00	06500	RESPIRATORY THERAPY	2,936,682	0	2,936,682	65.00
66.00	06600	PHYSICAL THERAPY	4,707,294	-58,831	4,648,463	66.00
69.00	06900	ELECTROCARDIOLOGY	9,816,674	0	9,816,674	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	417,587	0	417,587	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,356,798	0	11,356,798	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,260,677	0	13,260,677	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,907,140	0	12,907,140	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,558,220	-491,880	2,066,340	88.00
91.00	09100	EMERGENCY	8,448,519	-87,078	8,361,441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	188,327,495	-1,172,501	187,154,994	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,093	0	3,093	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	235,575	0	235,575	192.00
192.01	19201	FAMILY PRACTICE	1,680,939	-1,672,328	8,611	192.01
192.02	19202	UNUSED SPACE	100,965	0	100,965	192.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	190,348,067	-2,844,829	187,503,238	202.00

COST ALLOCATION STATISTICS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet Non-CMS W
Date/Time Prepared:
8/24/2015 1:06 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	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.01	DATA PROCESSING	5	NUMBER OF PCS	5.01
5.02	PURCHASING RECEIVING AND STORES	6	PURCHASING SUPPLIES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	7	GROSS REVENUE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.04
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	8	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	9	MEALS SERVED	10.00
11.00	CAFETERIA	10	NUMBER OF FTES	11.00
13.00	NURSING ADMINISTRATION	11	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	12	COSTED REQS	14.00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16.00
19.00	NONPHYSICIAN ANESTHETISTS	13	ASSIGNED TIME	19.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	14	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	14	ASSIGNED TIME	22.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet B
Part II
Date/Time Prepared:
8/24/2015 1:06 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	18,151	6,465	24,616	24,616 4.00
5.01 00550	DATA PROCESSING	0	24,145	0	24,145	0 5.01
5.02 00560	PURCHASING RECEIVING AND STORES	0	51,614	32,334	83,948	0 5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	50,829	1,703	52,532	284 5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	0	980,078	182,138	1,162,216	1,254 5.04
6.00 00600	MAINTENANCE & REPAIRS	0	650,107	10,342	660,449	283 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	16,331	0	16,331	18 8.00
9.00 00900	HOUSEKEEPING	0	38,239	4,678	42,917	443 9.00
10.00 01000	DIETARY	0	73,388	42,690	116,078	147 10.00
11.00 01100	CAFETERIA	0	82,388	169	82,557	434 11.00
13.00 01300	NURSING ADMINISTRATION	0	69,230	317,959	387,189	448 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	50,078	115,819	165,897	144 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	7,644	7,644	220 16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	425 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,074,187	474,072	1,548,259	5,527 30.00
31.00 03100	INTENSIVE CARE UNIT	0	117,104	185,922	303,026	1,254 31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	31,025	119,284	150,309	527 35.00
43.00 04300	NURSERY	0	15,262	8,326	23,588	3 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	339,355	2,077,902	2,417,257	2,145 50.00
50.01 05001	SAME DAY SURGERY	0	0	0	0	0 50.01
51.00 05100	RECOVERY ROOM	0	64,071	71,041	135,112	287 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	154,173	129,643	283,816	1,541 52.00
53.00 05300	ANESTHESIOLOGY	0	6,996	131,227	138,223	17 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	145,507	1,691,164	1,836,671	1,201 54.00
54.01 03480	ONCOLOGY	0	115,718	1,264,681	1,380,399	389 54.01
54.02 03440	MAMMOGRAPHY	0	0	368,164	368,164	262 54.02
56.00 05600	RADIOISOTOPE	0	30,006	155,458	185,464	135 56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	21,056	943,501	964,557	91 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	215,088	1,191,407	1,406,495	1,397 59.00
60.00 06000	LABORATORY	0	96,749	374,718	471,467	959 60.00
64.00 06400	INTRAVENOUS THERAPY	0	6,312	0	6,312	22 64.00
65.00 06500	RESPIRATORY THERAPY	0	20,906	86,773	107,679	563 65.00
66.00 06600	PHYSICAL THERAPY	0	2,405	35,433	37,838	883 66.00
69.00 06900	ELECTROCARDIOLOGY	0	37,437	445,267	482,704	474 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	13,442	73,336	86,778	40 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	32,344	34,920	67,264	1,172 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	11,929	11,929	168 88.00
91.00 09100	EMERGENCY	0	151,652	365,705	517,357	1,459 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	4,795,373	10,961,814	15,757,187	24,616 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,002	0	1,002	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	20,572	2,375	22,947	0 192.00
192.01 19201	FAMILY PRACTICE	0	2,789	0	2,789	0 192.01
192.02 19202	UNUSED SPACE	0	32,695	0	32,695	0 192.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	4,852,431	10,964,189	15,816,620	24,616 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet B Part II Date/Time Prepared: 8/24/2015 1:06 pm
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Cost Center Description		DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS		
		5.01	5.02	5.03	5.04	6.00		
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	
5.01	00550	DATA PROCESSING	24,145				5.01	
5.02	00560	PURCHASING RECEIVING AND STORES	25	83,973			5.02	
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	516	185	53,517		5.03	
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,893	4	0	1,165,367	5.04	
6.00	00600	MAINTENANCE & REPAIRS	516	0	0	22,347	6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	22	0	8,745	8.00	
9.00	00900	HOUSEKEEPING	98	16	0	14,193	9.00	
10.00	01000	DIETARY	295	18	0	6,628	10.00	
11.00	01100	CAFETERIA	0	54	0	9,668	11.00	
13.00	01300	NURSING ADMINISTRATION	246	0	0	13,731	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	98	200	0	5,162	14.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	566	0	0	5,910	16.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	9,811	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	7,381	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,531	12,658	2,953	178,314	238,605	30.00
31.00	03100	INTENSIVE CARE UNIT	861	4,274	394	37,707	26,012	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	172	168	597	14,321	6,891	35.00
43.00	04300	NURSERY	49	1,044	128	1,447	3,390	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,164	38,672	7,749	109,566	75,380	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	295	217	756	8,804	14,232	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	590	2,015	557	41,454	34,246	52.00
53.00	05300	ANESTHESIOLOGY	25	4,321	1,084	5,642	1,554	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	934	4,204	6,595	55,056	32,321	54.00
54.01	03480	ONCOLOGY	762	6	2,314	27,386	25,704	54.01
54.02	03440	MAMMOGRAPHY	861	109	556	13,741	0	54.02
56.00	05600	RADIOISOTOPE	123	91	1,134	14,417	6,665	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	25	72	1,273	10,533	4,677	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,500	8,815	3,013	86,140	47,777	59.00
60.00	06000	LABORATORY	984	1,394	5,609	61,637	21,490	60.00
64.00	06400	INTRAVENOUS THERAPY	49	90	0	751	1,402	64.00
65.00	06500	RESPIRATORY THERAPY	197	832	804	17,231	4,644	65.00
66.00	06600	PHYSICAL THERAPY	1,401	239	1,064	27,905	534	66.00
69.00	06900	ELECTROCARDIOLOGY	566	408	3,521	58,987	8,316	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	49	8	68	2,358	2,986	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,070	69,174	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,763	80,757	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	516	115	3,790	77,867	7,184	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,033	71	93	12,493	0	88.00
91.00	09100	EMERGENCY	1,205	3,651	2,632	46,659	33,686	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,145	83,973	53,517	1,163,923	670,921	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7	223	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,194	4,570	192.00
192.01	19201	FAMILY PRACTICE	0	0	0	19	619	192.01
192.02	19202	UNUSED SPACE	0	0	0	224	7,262	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24,145	83,973	53,517	1,165,367	683,595	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet B Part II Date/Time Prepared: 8/24/2015 1:06 pm
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
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
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,743				8.00
9.00	00900	HOUSEKEEPING	0	66,161			9.00
10.00	01000	DIETARY	0	1,606	141,073		10.00
11.00	01100	CAFETERIA	0	1,803	0	112,817	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,515	0	1,382	419,889
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,096	0	1,508	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,010	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	2,387	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	23,995	23,511	117,772	30,025	172,074
31.00	03100	INTENSIVE CARE UNIT	3,181	2,563	15,612	5,528	31,307
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,567	679	7,689	2,261	13,189
43.00	04300	NURSERY	0	334	0	0	94
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	7,427	0	11,935	67,914
50.01	05001	SAME DAY SURGERY	0	0	0	0	0
51.00	05100	RECOVERY ROOM	0	1,402	0	1,005	6,056
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,374	0	7,664	43,705
53.00	05300	ANESTHESIOLOGY	0	153	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,185	0	5,779	0
54.01	03480	ONCOLOGY	0	2,533	0	1,884	0
54.02	03440	MAMMOGRAPHY	0	0	0	1,884	0
56.00	05600	RADIOISOTOPE	0	657	0	503	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	461	0	503	0
59.00	05900	CARDIAC CATHETERIZATION	0	4,707	0	6,407	36,774
60.00	06000	LABORATORY	0	2,117	0	6,407	0
64.00	06400	INTRAVENOUS THERAPY	0	138	0	126	0
65.00	06500	RESPIRATORY THERAPY	0	458	0	3,141	2,149
66.00	06600	PHYSICAL THERAPY	0	53	0	4,271	0
69.00	06900	ELECTROCARDIOLOGY	0	819	0	2,764	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	294	0	251	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	708	0	3,518	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,508	0
91.00	09100	EMERGENCY	0	3,319	0	8,166	46,627
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,743	64,912	141,073	112,817	419,889
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	450	0	0	0
192.01	19201	FAMILY PRACTICE	0	61	0	0	0
192.02	19202	UNUSED SPACE	0	716	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)	28,743	66,161	141,073	112,817	419,889

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet B
Part II
Date/Time Prepared:
8/24/2015 1:06 pm

Cost Center Description	INTERNS & RESIDENTS					
	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	
	14.00	16.00	19.00	21.00	22.00	
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
5.01 00550	DATA PROCESSING					5.01
5.02 00560	PURCHASING RECEIVING AND STORES					5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00 00600	MAINTENANCE & REPAIRS					6.00
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	185,229				14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	16,350			16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		10,236	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0			22.00
						9,768
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	59	890			30.00
31.00 03100	INTENSIVE CARE UNIT	369	119			31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	180			35.00
43.00 04300	NURSERY	1	38			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	100,753	2,557			50.00
50.01 05001	SAME DAY SURGERY	0	0			50.01
51.00 05100	RECOVERY ROOM	0	228			51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	93	168			52.00
53.00 05300	ANESTHESIOLOGY	1,385	327			53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	7,801	1,987			54.00
54.01 03480	ONCOLOGY	57	697			54.01
54.02 03440	MAMMOGRAPHY	540	168			54.02
56.00 05600	RADIOISOTOPE	0	342			56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	27	384			58.00
59.00 05900	CARDIAC CATHETERIZATION	72,354	908			59.00
60.00 06000	LABORATORY	194	1,690			60.00
64.00 06400	INTRAVENOUS THERAPY	15	0			64.00
65.00 06500	RESPIRATORY THERAPY	1,037	242			65.00
66.00 06600	PHYSICAL THERAPY	1	321			66.00
69.00 06900	ELECTROCARDIOLOGY	7	1,061			69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	160	21			70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	172	925			71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,134			72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	1,142			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	152	28			88.00
91.00 09100	EMERGENCY	52	793			91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	185,229	16,350	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0			192.00
192.01 19201	FAMILY PRACTICE	0	0			192.01
192.02 19202	UNUSED SPACE	0	0			192.02
200.00	Cross Foot Adjustments			0	10,236	9,768
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	185,229	16,350	0	10,236	9,768

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet B Part II Date/Time Prepared: 8/24/2015 1:06 pm
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00550				5.01
5.02	00560				5.02
5.03	00580				5.03
5.04	00590				5.04
6.00	00600				6.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
16.00	01600				16.00
19.00	01900				19.00
21.00	02100				21.00
22.00	02200				22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	2,360,173	0	2,360,173	30.00
31.00	03100	432,207	0	432,207	31.00
35.00	02060	198,550	0	198,550	35.00
43.00	04300	30,116	0	30,116	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	2,843,519	0	2,843,519	50.00
50.01	05001	0	0	0	50.01
51.00	05100	168,394	0	168,394	51.00
52.00	05200	419,223	0	419,223	52.00
53.00	05300	152,731	0	152,731	53.00
54.00	05400	1,955,734	0	1,955,734	54.00
54.01	03480	1,442,131	0	1,442,131	54.01
54.02	03440	386,285	0	386,285	54.02
56.00	05600	209,531	0	209,531	56.00
58.00	05800	982,603	0	982,603	58.00
59.00	05900	1,676,287	0	1,676,287	59.00
60.00	06000	573,948	0	573,948	60.00
64.00	06400	8,905	0	8,905	64.00
65.00	06500	138,977	0	138,977	65.00
66.00	06600	74,510	0	74,510	66.00
69.00	06900	559,627	0	559,627	69.00
70.00	07000	93,013	0	93,013	70.00
71.00	07100	73,341	0	73,341	71.00
72.00	07200	85,654	0	85,654	72.00
73.00	07300	163,276	0	163,276	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	27,475	0	27,475	88.00
91.00	09100	665,606	0	665,606	91.00
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		15,721,816	0	15,721,816	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	1,254	0	1,254	190.00
192.00	19200	29,161	0	29,161	192.00
192.01	19201	3,488	0	3,488	192.01
192.02	19202	40,897	0	40,897	192.02
200.00		20,004	0	20,004	200.00
201.00		0	0	0	201.00
202.00		15,816,620	0	15,816,620	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet B-1

Date/Time Prepared:
8/24/2015 1:06 pm

Cost Center Description	CAPITAL RELATED COSTS					EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (NUMBER OF PCS)	PURCHASING RECEIVING AND STORES (PURCHASING SUPPLIES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)							
	1.00	2.00	4.00	5.01	5.02				
GENERAL SERVICE COST CENTERS									
1.00 00100	CAP REL COSTS-BLDG & FIXT	290,598							1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		5,189,526						2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,087	3,060	59,296,875					4.00
5.01 00550	DATA PROCESSING	1,446	0	0		982			5.01
5.02 00560	PURCHASING RECEIVING AND STORES	3,091	15,304	0		1	10,727,495		5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	3,044	806	683,325		21	23,679		5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	58,694	86,209	3,022,089		77	449		5.04
6.00 00600	MAINTENANCE & REPAIRS	38,933	4,895	681,223		21	0		6.00
8.00 00800	LAUNDRY & LINEN SERVICE	978	0	43,246		0	2,757		8.00
9.00 00900	HOUSEKEEPING	2,290	2,214	1,067,745		4	2,091		9.00
10.00 01000	DIETARY	4,395	20,206	354,067		12	2,341		10.00
11.00 01100	CAFETERIA	4,934	80	1,046,801		0	6,922		11.00
13.00 01300	NURSING ADMINISTRATION	4,146	150,495	1,079,282		10	0		13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,999	54,819	346,486		4	25,517		14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	3,618	530,644		23	0		16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0		0	0		19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,023,997		0	0		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0		0	0		22.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00 03000	ADULTS & PEDIATRICS	64,330	224,386	13,298,531		225	1,617,051		30.00
31.00 03100	INTENSIVE CARE UNIT	7,013	88,000	3,022,185		35	546,036		31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	1,858	56,459	1,270,709		7	21,425		35.00
43.00 04300	NURSERY	914	3,941	8,033		2	133,417		43.00
ANCILLARY SERVICE COST CENTERS									
50.00 05000	OPERATING ROOM	20,323	983,504	5,168,794		88	4,940,430		50.00
50.01 05001	SAME DAY SURGERY	0	0	0		0	0		50.01
51.00 05100	RECOVERY ROOM	3,837	33,625	691,505		12	27,737		51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	9,233	61,362	3,712,222		24	257,366		52.00
53.00 05300	ANESTHESIOLOGY	419	62,112	40,952		1	552,041		53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,714	800,455	2,894,752		38	537,050		54.00
54.01 03480	ONCOLOGY	6,930	598,594	937,886		31	752		54.01
54.02 03440	MAMMOGRAPHY	0	174,258	630,381		35	13,885		54.02
56.00 05600	RADIOISOTOPE	1,797	73,581	326,286		5	11,617		56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,261	446,574	219,319		1	9,261		58.00
59.00 05900	CARDIAC CATHETERIZATION	12,881	563,912	3,365,838		61	1,126,023		59.00
60.00 06000	LABORATORY	5,794	177,360	2,311,163		40	178,067		60.00
64.00 06400	INTRAVENOUS THERAPY	378	0	53,540		2	11,464		64.00
65.00 06500	RESPIRATORY THERAPY	1,252	41,071	1,355,852		8	106,327		65.00
66.00 06600	PHYSICAL THERAPY	144	16,771	2,127,481		57	30,552		66.00
69.00 06900	ELECTROCARDIOLOGY	2,242	210,752	1,141,558		23	52,132		69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	805	34,711	96,593		2	994		70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		0	0		71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	0		72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,937	16,528	2,823,417		21	14,749		73.00
OUTPATIENT SERVICE COST CENTERS									
88.00 08800	RURAL HEALTH CLINIC	0	5,646	405,111		42	9,018		88.00
91.00 09100	EMERGENCY	9,082	173,094	3,515,862		49	466,345		91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)								92.00
SPECIAL PURPOSE COST CENTERS									
113.00 11300	INTEREST EXPENSE								113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	287,181	5,188,402	59,296,875		982	10,727,495		118.00
NONREIMBURSABLE COST CENTERS									
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	60	0	0		0	0		190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,232	1,124	0		0	0		192.00
192.01 19201	FAMILY PRACTICE	167	0	0		0	0		192.01
192.02 19202	UNUSED SPACE	1,958	0	0		0	0		192.02
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)	4,852,431	10,964,189	23,542,387		6,013,689	206,539		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	16.698088	2.112753	0.397026		6,123.919552	0.019253		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			24,616		24,145	83,973		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000415		24.587576	0.007828		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet B-1

Date/Time Prepared:
8/24/2015 1:06 pm

Cost Center Description		CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
		5.03	5A.04	5.04	6.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00560						5.02
5.03	00580	733,594,120					5.03
5.04	00590	0	-20,420,902	169,927,165			5.04
6.00	00600	0	0	3,258,460	184,303		6.00
8.00	00800	0	0	1,275,216	978	34,825	8.00
9.00	00900	0	0	2,069,595	2,290	0	9.00
10.00	01000	0	0	966,486	4,395	0	10.00
11.00	01100	0	0	1,409,742	4,934	0	11.00
13.00	01300	0	0	2,002,173	4,146	0	13.00
14.00	01400	0	0	752,712	2,999	0	14.00
16.00	01600	0	0	861,785	0	0	16.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	1,430,550	0	0	21.00
22.00	02200	0	0	1,076,192	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	40,458,720	0	26,000,060	64,330	29,073	30.00
31.00	03100	5,396,242	0	5,498,261	7,013	3,854	31.00
35.00	02060	8,182,763	0	2,088,255	1,858	1,898	35.00
43.00	04300	1,747,915	0	211,035	914	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	106,619,882	0	15,976,339	20,323	0	50.00
50.01	05001	0	0	0	0	0	50.01
51.00	05100	10,350,008	0	1,283,809	3,837	0	51.00
52.00	05200	7,632,642	0	6,044,561	9,233	0	52.00
53.00	05300	14,843,020	0	822,638	419	0	53.00
54.00	05400	90,336,131	0	8,028,006	8,714	0	54.00
54.01	03480	31,697,209	0	3,993,254	6,930	0	54.01
54.02	03440	7,621,029	0	2,003,603	0	0	54.02
56.00	05600	15,532,654	0	2,102,270	1,797	0	56.00
58.00	05800	17,435,333	0	1,535,823	1,261	0	58.00
59.00	05900	41,274,641	0	12,560,509	12,881	0	59.00
60.00	06000	76,839,310	0	8,987,589	5,794	0	60.00
64.00	06400	3,515	0	109,519	378	0	64.00
65.00	06500	11,018,970	0	2,512,477	1,252	0	65.00
66.00	06600	14,580,099	0	4,069,009	144	0	66.00
69.00	06900	48,231,145	0	8,601,166	2,242	0	69.00
70.00	07000	934,581	0	343,832	805	0	70.00
71.00	07100	42,052,156	0	10,086,642	0	0	71.00
72.00	07200	51,545,590	0	11,775,562	0	0	72.00
73.00	07300	51,920,385	0	11,354,207	1,937	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1,278,933	0	1,821,628	0	0	88.00
91.00	09100	36,061,247	0	6,803,553	9,082	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		733,594,120	-20,420,902	169,716,518	180,886	34,825	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	1,002	60	0	190.00
192.00	19200	0	0	174,161	1,232	0	192.00
192.01	19201	0	0	2,789	167	0	192.01
192.02	19202	0	0	32,695	1,958	0	192.02
200.00							200.00
201.00							201.00
202.00		4,577,761		20,420,902	3,650,042	1,447,833	202.00
203.00		0.006240		0.120174	19.804572	41.574530	203.00
204.00		53,517		1,165,367	683,595	28,743	204.00
205.00		0.000073		0.006858	3.709082	0.825355	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet B-1

Date/Time Prepared:
8/24/2015 1:06 pm

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQS)	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00560						5.02
5.03	00580						5.03
5.04	00590						5.04
6.00	00600						6.00
8.00	00800						8.00
9.00	00900	181,035					9.00
10.00	01000	4,395	104,475				10.00
11.00	01100	4,934	0	898			11.00
13.00	01300	4,146	0	11	1,215,657		13.00
14.00	01400	2,999	0	12	0	20,412,803	14.00
16.00	01600	0	0	16	0	0	16.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	19	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	64,330	87,219	239	498,181	6,460	30.00
31.00	03100	7,013	11,562	44	90,641	40,705	31.00
35.00	02060	1,858	5,694	18	38,185	0	35.00
43.00	04300	914	0	0	272	61	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	20,323	0	95	196,625	11,102,945	50.00
50.01	05001	0	0	0	0	0	50.01
51.00	05100	3,837	0	8	17,534	0	51.00
52.00	05200	9,233	0	61	126,533	10,299	52.00
53.00	05300	419	0	0	0	152,609	53.00
54.00	05400	8,714	0	46	0	859,732	54.00
54.01	03480	6,930	0	15	0	6,310	54.01
54.02	03440	0	0	15	0	59,508	54.02
56.00	05600	1,797	0	4	0	0	56.00
58.00	05800	1,261	0	4	0	2,950	58.00
59.00	05900	12,881	0	51	106,469	7,973,799	59.00
60.00	06000	5,794	0	51	0	21,388	60.00
64.00	06400	378	0	1	0	1,669	64.00
65.00	06500	1,252	0	25	6,222	114,272	65.00
66.00	06600	144	0	34	0	95	66.00
69.00	06900	2,242	0	22	0	817	69.00
70.00	07000	805	0	2	0	17,667	70.00
71.00	07100	0	0	0	0	18,966	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	1,937	0	28	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	12	0	16,787	88.00
91.00	09100	9,082	0	65	134,995	5,764	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		177,618	104,475	898	1,215,657	20,412,803	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	60	0	0	0	0	190.00
192.00	19200	1,232	0	0	0	0	192.00
192.01	19201	167	0	0	0	0	192.01
192.02	19202	1,958	0	0	0	0	192.02
200.00							200.00
201.00							201.00
202.00		2,363,659	1,227,056	1,741,292	2,400,354	964,987	202.00
203.00		13.056365	11.744972	1,939.077951	1.974532	0.047274	203.00
204.00		66,161	141,073	112,817	419,889	185,229	204.00
205.00		0.365460	1.350304	125.631403	0.345401	0.009074	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet B-1

Date/Time Prepared:
8/24/2015 1:06 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS			
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
			16.00	19.00		21.00
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
5.01 00550	DATA PROCESSING					5.01
5.02 00560	PURCHASING RECEIVING AND STORES					5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00 00600	MAINTENANCE & REPAIRS					6.00
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
16.00 01600	MEDICAL RECORDS & LIBRARY	733,594,120				16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	100			19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0		52,272		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0			52,272	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	40,458,720		7,493	7,493	30.00
31.00 03100	INTENSIVE CARE UNIT	5,396,242		0	0	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	8,182,763		0	0	35.00
43.00 04300	NURSERY	1,747,915		0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	106,619,882	0	1,660	1,660	50.00
50.01 05001	SAME DAY SURGERY	0	0	0	0	50.01
51.00 05100	RECOVERY ROOM	10,350,008	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	7,632,642	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	14,843,020	100	176	176	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	90,336,131	0	496	496	54.00
54.01 03480	ONCOLOGY	31,697,209	0	0	0	54.01
54.02 03440	MAMMOGRAPHY	7,621,029	0	0	0	54.02
56.00 05600	RADIOISOTOPE	15,532,654	0	0	0	56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	17,435,333	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	41,274,641	0	0	0	59.00
60.00 06000	LABORATORY	76,839,310	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	3,515	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	11,018,970	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	14,580,099	0	1,081	1,081	66.00
69.00 06900	ELECTROCARDIOLOGY	48,231,145	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	934,581	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,052,156	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	51,545,590	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	51,920,385	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	1,278,933	0	9,038	9,038	88.00
91.00 09100	EMERGENCY	36,061,247	0	1,600	1,600	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	733,594,120	100	21,544	21,544	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	FAMILY PRACTICE	0	0	30,728	30,728	192.01
192.02 19202	UNUSED SPACE	0	0	0	0	192.02
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)	996,374	0	1,602,465	1,242,364	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.001358	0.000000	30.656279	23.767294	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	16,350	0	10,236	9,768	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000022	0.000000	0.195822	0.186869	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet C
Part I
Date/Time Prepared:
8/24/2015 1:06 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		34,974,060	0	34,974,060	30.00
31.00	03100 INTENSIVE CARE UNIT		6,959,030	19,325	6,978,355	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		2,667,462	29,069	2,696,531	35.00
43.00	04300 NURSERY		269,345	0	269,345	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		19,806,385	0	19,806,385	50.00
50.01	05001 SAME DAY SURGERY		0	0	0	50.01
51.00	05100 RECOVERY ROOM		1,628,365	0	1,628,365	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		7,453,344	0	7,453,344	52.00
53.00	05300 ANESTHESIOLOGY		962,638	0	962,638	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		9,531,631	0	9,531,631	54.00
54.01	03480 ONCOLOGY		4,773,295	54,379	4,827,674	54.01
54.02	03440 MAMMOGRAPHY		2,286,632	12,456	2,299,088	54.02
56.00	05600 RADIOISOTOPE		2,442,808	0	2,442,808	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,793,399	0	1,793,399	58.00
59.00	05900 CARDIAC CATHETERIZATION		15,235,361	13,301	15,248,662	59.00
60.00	06000 LABORATORY		10,462,313	0	10,462,313	60.00
64.00	06400 INTRAVENOUS THERAPY		137,124	0	137,124	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,936,682	0	2,936,682	65.00
66.00	06600 PHYSICAL THERAPY	0	4,648,463	0	4,648,463	66.00
69.00	06900 ELECTROCARDIOLOGY		9,816,674	0	9,816,674	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		417,587	0	417,587	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		11,356,798	0	11,356,798	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		13,260,677	0	13,260,677	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		12,907,140	0	12,907,140	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		2,066,340	0	2,066,340	88.00
91.00	09100 EMERGENCY		8,361,441	9,142	8,370,583	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		4,214,094	0	4,214,094	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		191,369,088	0	191,369,088	200.00
201.00	Less Observation Beds		4,214,094		4,214,094	201.00
202.00	Total (see instructions)		187,154,994	0	187,154,994	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet C Part I Date/Time Prepared: 8/24/2015 1:06 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				
	9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34,082,093		34,082,093		30.00
31.00	03100	INTENSIVE CARE UNIT	5,396,242		5,396,242		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	8,178,653		8,178,653		35.00
43.00	04300	NURSERY	1,747,915		1,747,915		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	62,549,585	43,018,515	105,568,100	0.187617	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0.000000	50.01
51.00	05100	RECOVERY ROOM	5,210,975	4,798,675	10,009,650	0.162680	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,465,385	3,084,826	7,550,211	0.987170	52.00
53.00	05300	ANESTHESIOLOGY	8,624,520	6,056,179	14,680,699	0.065572	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,434,369	64,737,572	89,171,941	0.106890	54.00
54.01	03480	ONCOLOGY	384,939	31,148,386	31,533,325	0.151373	54.01
54.02	03440	MAMMOGRAPHY	0	7,463,341	7,463,341	0.306382	54.02
56.00	05600	RADIOISOTOPE	4,123,547	11,143,124	15,266,671	0.160009	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,686,497	14,189,175	16,875,672	0.106271	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,301,296	24,590,712	40,892,008	0.372576	59.00
60.00	06000	LABORATORY	36,757,606	38,428,947	75,186,553	0.139151	60.00
64.00	06400	INTRAVENOUS THERAPY	0	3,515	3,515	39.011095	64.00
65.00	06500	RESPIRATORY THERAPY	9,723,473	1,283,260	11,006,733	0.266808	65.00
66.00	06600	PHYSICAL THERAPY	3,402,762	10,789,498	14,192,260	0.327535	66.00
69.00	06900	ELECTROCARDIOLOGY	11,726,140	34,308,528	46,034,668	0.213245	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	506,081	423,208	929,289	0.449362	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,878,973	18,319,764	38,198,737	0.297308	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,507,018	23,731,666	51,238,684	0.258802	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,410,104	18,802,994	55,213,098	0.233770	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,278,933	1,278,933		88.00
91.00	09100	EMERGENCY	7,241,660	28,512,463	35,754,123	0.233859	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	831,309	5,424,653	6,255,962	0.673612	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	332,171,142	391,537,934	723,709,076		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	332,171,142	391,537,934	723,709,076		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet C Part I Date/Time Prepared: 8/24/2015 1:06 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT			35.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.187617		50.00
50.01	05001 SAME DAY SURGERY	0.000000		50.01
51.00	05100 RECOVERY ROOM	0.162680		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.987170		52.00
53.00	05300 ANESTHESIOLOGY	0.065572		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.106890		54.00
54.01	03480 ONCOLOGY	0.153098		54.01
54.02	03440 MAMMOGRAPHY	0.308051		54.02
56.00	05600 RADIOISOTOPE	0.160009		56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.106271		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.372901		59.00
60.00	06000 LABORATORY	0.139151		60.00
64.00	06400 INTRAVENOUS THERAPY	39.011095		64.00
65.00	06500 RESPIRATORY THERAPY	0.266808		65.00
66.00	06600 PHYSICAL THERAPY	0.327535		66.00
69.00	06900 ELECTROCARDIOLOGY	0.213245		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.449362		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297308		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.258802		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.233770		73.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC			88.00
91.00	09100 EMERGENCY	0.234115		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.673612		92.00
	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: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet C Part I Date/Time Prepared: 8/24/2015 1:06 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		34,974,060	0	34,974,060	30.00
31.00	03100 INTENSIVE CARE UNIT		6,959,030	19,325	6,978,355	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		2,667,462	29,069	2,696,531	35.00
43.00	04300 NURSERY		269,345	0	269,345	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		19,806,385	0	19,806,385	50.00
50.01	05001 SAME DAY SURGERY		0	0	0	50.01
51.00	05100 RECOVERY ROOM		1,628,365	0	1,628,365	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		7,453,344	0	7,453,344	52.00
53.00	05300 ANESTHESIOLOGY		962,638	0	962,638	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		9,531,631	0	9,531,631	54.00
54.01	03480 ONCOLOGY		4,773,295	54,379	4,827,674	54.01
54.02	03440 MAMMOGRAPHY		2,286,632	12,456	2,299,088	54.02
56.00	05600 RADIOISOTOPE		2,442,808	0	2,442,808	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,793,399	0	1,793,399	58.00
59.00	05900 CARDIAC CATHETERIZATION		15,235,361	13,301	15,248,662	59.00
60.00	06000 LABORATORY		10,462,313	0	10,462,313	60.00
64.00	06400 INTRAVENOUS THERAPY		137,124	0	137,124	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,936,682	0	2,936,682	65.00
66.00	06600 PHYSICAL THERAPY	0	4,648,463	0	4,648,463	66.00
69.00	06900 ELECTROCARDIOLOGY		9,816,674	0	9,816,674	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		417,587	0	417,587	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		11,356,798	0	11,356,798	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		13,260,677	0	13,260,677	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		12,907,140	0	12,907,140	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		2,066,340	0	2,066,340	88.00
91.00	09100 EMERGENCY		8,361,441	9,142	8,370,583	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		4,214,094	0	4,214,094	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		191,369,088	0	191,369,088	200.00
201.00	Less Observation Beds		4,214,094		4,214,094	201.00
202.00	Total (see instructions)		187,154,994	0	187,154,994	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet C Part I Date/Time Prepared: 8/24/2015 1:06 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	34,082,093		34,082,093	30.00
31.00	03100	INTENSIVE CARE UNIT	5,396,242		5,396,242	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	8,178,653		8,178,653	35.00
43.00	04300	NURSERY	1,747,915		1,747,915	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	62,549,585	43,018,515	105,568,100	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	50.01
51.00	05100	RECOVERY ROOM	5,210,975	4,798,675	10,009,650	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,465,385	3,084,826	7,550,211	52.00
53.00	05300	ANESTHESIOLOGY	8,624,520	6,056,179	14,680,699	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,434,369	64,737,572	89,171,941	54.00
54.01	03480	ONCOLOGY	384,939	31,148,386	31,533,325	54.01
54.02	03440	MAMMOGRAPHY	0	7,463,341	7,463,341	54.02
56.00	05600	RADIOISOTOPE	4,123,547	11,143,124	15,266,671	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,686,497	14,189,175	16,875,672	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,301,296	24,590,712	40,892,008	59.00
60.00	06000	LABORATORY	36,757,606	38,428,947	75,186,553	60.00
64.00	06400	INTRAVENOUS THERAPY	0	3,515	3,515	64.00
65.00	06500	RESPIRATORY THERAPY	9,723,473	1,283,260	11,006,733	65.00
66.00	06600	PHYSICAL THERAPY	3,402,762	10,789,498	14,192,260	66.00
69.00	06900	ELECTROCARDIOLOGY	11,726,140	34,308,528	46,034,668	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	506,081	423,208	929,289	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,878,973	18,319,764	38,198,737	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,507,018	23,731,666	51,238,684	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,410,104	18,802,994	55,213,098	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,278,933	1,278,933	88.00
91.00	09100	EMERGENCY	7,241,660	28,512,463	35,754,123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	831,309	5,424,653	6,255,962	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	332,171,142	391,537,934	723,709,076	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	332,171,142	391,537,934	723,709,076	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet C Part I Date/Time Prepared: 8/24/2015 1:06 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
35.00	02060 NEONATAL INTENSIVE CARE UNIT			35.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
50.01	05001 SAME DAY SURGERY	0.000000		50.01
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
54.01	03480 ONCOLOGY	0.000000		54.01
54.02	03440 MAMMOGRAPHY	0.000000		54.02
56.00	05600 RADIOISOTOPE	0.000000		56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	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
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
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: 140164		Period: From 04/01/2014 To 03/31/2015		Worksheet D Part I Date/Time Prepared: 8/24/2015 1:06 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	2,360,173	0	2,360,173	33,056	71.40	30.00
31.00	INTENSIVE CARE UNIT	432,207		432,207	3,854	112.15	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	198,550		198,550	1,898	104.61	35.00
43.00	NURSERY	30,116		30,116	2,924	10.30	43.00
200.00	Total (Lines 30-199)	3,021,046		3,021,046	41,732		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	13,017	929,414				
31.00	INTENSIVE CARE UNIT	1,709	191,664				
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	14,726	1,121,078				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet D Part II Date/Time Prepared: 8/24/2015 1:06 pm
		Title XVIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,843,519	105,568,100	0.026935	28,864,108	777,455	50.00
50.01	05001 SAME DAY SURGERY	0	0	0.000000	0	0	50.01
51.00	05100 RECOVERY ROOM	168,394	10,009,650	0.016823	2,038,398	34,292	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	419,223	7,550,211	0.055525	58,215	3,232	52.00
53.00	05300 ANESTHESIOLOGY	152,731	14,680,699	0.010404	3,400,918	35,383	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,955,734	89,171,941	0.021932	12,132,250	266,085	54.00
54.01	03480 ONCOLOGY	1,442,131	31,533,325	0.045734	245,892	11,246	54.01
54.02	03440 MAMMOGRAPHY	386,285	7,463,341	0.051758	0	0	54.02
56.00	05600 RADIOISOTOPE	209,531	15,266,671	0.013725	2,395,905	32,884	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	982,603	16,875,672	0.058226	1,216,388	70,825	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,676,287	40,892,008	0.040993	4,231,685	173,469	59.00
60.00	06000 LABORATORY	573,948	75,186,553	0.007634	18,078,905	138,014	60.00
64.00	06400 INTRAVENOUS THERAPY	8,905	3,515	2.533428	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	138,977	11,006,733	0.012627	4,863,790	61,415	65.00
66.00	06600 PHYSICAL THERAPY	74,510	14,192,260	0.005250	1,843,536	9,679	66.00
69.00	06900 ELECTROCARDIOLOGY	559,627	46,034,668	0.012157	6,444,551	78,346	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	93,013	929,289	0.100090	174,230	17,439	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	73,341	38,198,737	0.001920	7,791,751	14,960	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	85,654	51,238,684	0.001672	13,631,140	22,791	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	163,276	55,213,098	0.002957	16,956,112	50,139	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	27,475	1,278,933	0.021483	0	0	88.00
91.00	09100 EMERGENCY	665,606	35,754,123	0.018616	3,397,684	63,251	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	284,384	6,255,962	0.045458	513,254	23,332	92.00
200.00	Total (lines 50-199)	12,985,154	674,304,173		128,278,712	1,884,237	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet D Part III Date/Time Prepared: 8/24/2015 1:06 pm
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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	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	
43.00	04300	NURSERY	0	0	0	0	0	
200.00		Total (lines 30-199)	0	0	0	0	0	
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	33,056	0.00	13,017	0	0	
31.00	03100	INTENSIVE CARE UNIT	3,854	0.00	1,709	0	0	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,898	0.00	0	0	0	
43.00	04300	NURSERY	2,924	0.00	0	0	0	
200.00		Total (lines 30-199)	41,732		14,726	0	0	
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				
31.00	03100	INTENSIVE CARE UNIT	0	0				
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0				
43.00	04300	NURSERY	0	0				
200.00		Total (lines 30-199)	0	0				

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet D
Part IV
Date/Time Prepared:
8/24/2015 1:06 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
50.01	05001	SAME DAY SURGERY	0	0	0	0	0	0	50.01
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
54.01	03480	ONCOLOGY	0	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
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
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: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet D Part IV Date/Time Prepared: 8/24/2015 1:06 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	105,568,100	0.000000	0.000000	28,864,108	50.00
50.01	05001 SAME DAY SURGERY	0	0	0.000000	0.000000	0	50.01
51.00	05100 RECOVERY ROOM	0	10,009,650	0.000000	0.000000	2,038,398	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	7,550,211	0.000000	0.000000	58,215	52.00
53.00	05300 ANESTHESIOLOGY	0	14,680,699	0.000000	0.000000	3,400,918	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	89,171,941	0.000000	0.000000	12,132,250	54.00
54.01	03480 ONCOLOGY	0	31,533,325	0.000000	0.000000	245,892	54.01
54.02	03440 MAMMOGRAPHY	0	7,463,341	0.000000	0.000000	0	54.02
56.00	05600 RADIOISOTOPE	0	15,266,671	0.000000	0.000000	2,395,905	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	16,875,672	0.000000	0.000000	1,216,388	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	40,892,008	0.000000	0.000000	4,231,685	59.00
60.00	06000 LABORATORY	0	75,186,553	0.000000	0.000000	18,078,905	60.00
64.00	06400 INTRAVENOUS THERAPY	0	3,515	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	11,006,733	0.000000	0.000000	4,863,790	65.00
66.00	06600 PHYSICAL THERAPY	0	14,192,260	0.000000	0.000000	1,843,536	66.00
69.00	06900 ELECTROCARDIOLOGY	0	46,034,668	0.000000	0.000000	6,444,551	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	929,289	0.000000	0.000000	174,230	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	38,198,737	0.000000	0.000000	7,791,751	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	51,238,684	0.000000	0.000000	13,631,140	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	55,213,098	0.000000	0.000000	16,956,112	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	1,278,933	0.000000	0.000000	0	88.00
91.00	09100 EMERGENCY	0	35,754,123	0.000000	0.000000	3,397,684	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	6,255,962	0.000000	0.000000	513,254	92.00
200.00	Total (lines 50-199)	0	674,304,173			128,278,712	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet D
Part IV
Date/Time Prepared:
8/24/2015 1:06 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	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	15,868,537	0	0	0	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	2,890,972	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,545,189	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,597,045	0	0	0	54.00
54.01	03480	ONCOLOGY	0	11,379,916	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	9,423,010	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,113,855	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	7,816,695	0	0	0	59.00
60.00	06000	LABORATORY	0	6,811,719	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	358,213	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	306	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	7,034,117	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	66,164	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,694,797	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,943,065	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,936,429	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	5,460,575	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,461,418	0	0	0	92.00
200.00		Total (lines 50-199)	0	114,402,022	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet D Part IV Date/Time Prepared: 8/24/2015 1:06 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
50.01 05001 SAME DAY SURGERY	0	0		50.01
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
54.01 03480 ONCOLOGY	0	0		54.01
54.02 03440 MAMMOGRAPHY	0	0		54.02
56.00 05600 RADIOISOTOPE	0	0		56.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet D Part V Date/Time Prepared: 8/24/2015 1:06 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	0.187617	15,868,537	0	0	2,977,207	50.00
50.01	05001	SAME DAY SURGERY	0.000000	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0.162680	2,890,972	0	0	470,303	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.987170	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.065572	1,545,189	0	0	101,321	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106890	17,597,045	0	0	1,880,948	54.00
54.01	03480	ONCOLOGY	0.151373	11,379,916	0	0	1,722,612	54.01
54.02	03440	MAMMOGRAPHY	0.306382	0	9,210	0	0	54.02
56.00	05600	RADIOISOTOPE	0.160009	9,423,010	0	0	1,507,766	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.106271	3,113,855	0	0	330,912	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.372576	7,816,695	0	0	2,912,313	59.00
60.00	06000	LABORATORY	0.139151	6,811,719	1,155	0	947,858	60.00
64.00	06400	INTRAVENOUS THERAPY	39.011095	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.266808	358,213	0	0	95,574	65.00
66.00	06600	PHYSICAL THERAPY	0.327535	306	0	0	100	66.00
69.00	06900	ELECTROCARDIOLOGY	0.213245	7,034,117	0	0	1,499,990	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.449362	66,164	0	0	29,732	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297308	6,694,797	0	0	1,990,417	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.258802	11,943,065	0	0	3,090,889	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233770	4,936,429	0	114,856	1,153,989	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.233859	5,460,575	0	0	1,277,005	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.673612	1,461,418	0	0	984,429	92.00
200.00		Subtotal (see instructions)		114,402,022	10,365	114,856	22,973,365	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		114,402,022	10,365	114,856	22,973,365	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet D Part V Date/Time Prepared: 8/24/2015 1:06 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
50.01	05001 SAME DAY SURGERY	0	0	50.01
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
54.01	03480 ONCOLOGY	0	0	54.01
54.02	03440 MAMMOGRAPHY	2,822	0	54.02
56.00	05600 RADIOISOTOPE	0	0	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	161	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	26,850	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	2,983	26,850	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	2,983	26,850	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 8/24/2015 1:06 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		33,056	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		33,056	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)		29,073	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)		13,017	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)		34,974,060	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)		34,974,060	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)		34,974,060	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)		1,058.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		13,772,246	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)		13,772,246	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140164		Period: From 04/01/2014 To 03/31/2015		Worksheet D-1	
		Title XVIII		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	6,978,355	3,854	1,810.68	1,709	3,094,452	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	NEONATAL INTENSIVE CARE UNIT	2,696,531	1,898	1,420.72	0	0	47.00
Cost Center Description							
		1.00					
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					26,271,680	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					43,138,378	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)					1,121,078	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,884,237	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					3,005,315	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					40,133,063	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/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR 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)					3,983	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,058.02	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,214,094	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140164		Period: From 04/01/2014 To 03/31/2015		Worksheet D-1 Date/Time Prepared: 8/24/2015 1:06 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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,360,173	34,974,060	0.067484	4,214,094	284,384	90.00
91.00	Nursing School cost	0	34,974,060	0.000000	4,214,094	0	91.00
92.00	Allied health cost	0	34,974,060	0.000000	4,214,094	0	92.00
93.00	All other Medical Education	0	34,974,060	0.000000	4,214,094	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet D-3 Date/Time Prepared: 8/24/2015 1:06 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		12,316,406	30.00
31.00	03100	INTENSIVE CARE UNIT		2,337,912	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.187617	28,864,108	50.00
50.01	05001	SAME DAY SURGERY	0.000000	0	50.01
51.00	05100	RECOVERY ROOM	0.162680	2,038,398	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.987170	58,215	52.00
53.00	05300	ANESTHESIOLOGY	0.065572	3,400,918	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106890	12,132,250	54.00
54.01	03480	ONCOLOGY	0.153098	245,892	54.01
54.02	03440	MAMMOGRAPHY	0.308051	0	54.02
56.00	05600	RADIOISOTOPE	0.160009	2,395,905	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.106271	1,216,388	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.372901	4,231,685	59.00
60.00	06000	LABORATORY	0.139151	18,078,905	60.00
64.00	06400	INTRAVENOUS THERAPY	39.011095	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.266808	4,863,790	65.00
66.00	06600	PHYSICAL THERAPY	0.327535	1,843,536	66.00
69.00	06900	ELECTROCARDIOLOGY	0.213245	6,444,551	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.449362	174,230	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297308	7,791,751	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.258802	13,631,140	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233770	16,956,112	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100	EMERGENCY	0.234115	3,397,684	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.673612	513,254	92.00
200.00		Total (sum of lines 50-94 and 96-98)		128,278,712	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)		128,278,712	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet E Part A Date/Time Prepared: 8/24/2015 1:06 pm	
		Title XVIII	Hospital		PPS
		Before Geo Reclassification	On or After Geo Reclassification		
		0	1.00	1.01	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		14,919,974	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		0	17,039,559	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	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	0	1.04
2.00	Outlier payments for discharges. (see instructions)		501,032	264,359	2.00
2.01	Outlier reconciliation amount		0	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	0	2.02
3.00	Managed Care Simulated Payments		2,643,032	3,250,813	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		155.39		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)		5.17		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)		5.17		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		15.98		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)		5.17		12.00
13.00	Total allowable FTE count for the prior year.		5.17		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.		5.17		14.00
15.00	Sum of lines 12 through 14 divided by 3.		5.17		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		5.17		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.033271		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.032896		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.032896		21.00
22.00	IME payment adjustment (see instructions)		312,850	361,432	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	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).		7.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		10.81		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)		7.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.045048		26.00
27.00	IME payments adjustment factor. (see instructions)		0.011884		27.00
28.00	IME add-on adjustment amount (see instructions)		208,719	241,131	28.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet E Part A Date/Time Prepared: 8/24/2015 1:06 pm	
		Title XVIII	Hospital		PPS
		0	Before Geo Reclassification 1.00	On or After Geo Reclassification 1.01	2.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		521,569	602,563	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		7.33		30.00
31.00	Percentage of Medicaid patient days (see instructions)		28.96		31.00
32.00	Sum of lines 30 and 31		36.29		32.00
33.00	Allowable disproportionate share percentage (see instructions)		19.15	19.15	33.00
34.00	Disproportionate share adjustment (see instructions)		714,294	815,769	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)		0	0	35.00
35.01	Factor 3 (see instructions)		0.00000000	0.00000000	35.01
35.02	Hospital uncompensated care payment (if line 34 is zero, enter zero on this line) (see instructions)		2,870,377	2,227,556	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,439,121	1,110,726	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,549,847		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 1 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)		18,095,990	19,832,976	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	0	48.00
49.00	Total payment for inpatient operating costs (see instructions)		37,928,966		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,896,559		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).		388,429		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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet E Part A Date/Time Prepared: 8/24/2015 1:06 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00
59.00	Total (sum of amounts on lines 49 through 58)		41,213,954		59.00
60.00	Primary payer payments		26,615		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		41,187,339		61.00
62.00	Deductibles billed to program beneficiaries		3,259,380		62.00
63.00	Coinurance billed to program beneficiaries		41,227		63.00
64.00	Allowable bad debts (see instructions)		1,003,799		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		652,469		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		789,287		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		38,539,201		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)		-20,149		70.93
70.94	HRR adjustment amount (see instructions)		-45,795		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)		38,473,257		71.00
71.01	Sequestration adjustment (see instructions)		769,465		71.01
72.00	Interim payments		37,011,131		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)		692,661		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		74,826		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. 1, 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: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet E Part A Date/Time Prepared: 8/24/2015 1:06 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: 140164		Period: From 04/01/2014 To 03/31/2015		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 8/24/2015 1:06 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)	7.33	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	28.96	0.00			28.96	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	36.29	0.00			28.96	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	155.39	0.00			155.39	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	19.15	0.00			13.11	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)?	No				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)	7.33	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")	No				No	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)	9,623	0			9,623	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	21	0			21	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	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)	156	0			156	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	1,425	0			1,425	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	11,225	0			11,225	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	37,749	0			37,749	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	1,012	0			1,012	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)	38,761	0			38,761	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	28.96	0.00			28.96	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140164		Period: From 04/01/2014 To 03/31/2015		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 8/24/2015 1:06 pm	
		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	True	19.15		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		19.15		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.		19.15		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")	True				True	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)	Rural				Rural	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet DSH Date/Time Prepared: 8/24/2015 1:06 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	13.11	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	13.11	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.	13.11	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet E Part B Date/Time Prepared: 8/24/2015 1:06 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		29,833	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		22,973,365	2.00
3.00	PPS payments		19,526,399	3.00
4.00	Outlier payment (see instructions)		216,590	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.872	5.00
6.00	Line 2 times line 5		20,032,774	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		98.55	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)		29,833	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		125,221	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		125,221	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)		125,221	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		95,388	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)		29,833	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)		19,742,989	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)		3,865,404	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} (for CAH, see instructions)		15,907,418	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		209,181	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)		16,116,599	30.00
31.00	Primary payer payments		646	31.00
32.00	Subtotal (line 30 minus line 31)		16,115,953	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)		872,617	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		567,201	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		656,377	36.00
37.00	Subtotal (see instructions)		16,683,154	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)		16,683,154	40.00
40.01	Sequestration adjustment (see instructions)		333,663	40.01
41.00	Interim payments		16,136,605	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		212,886	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: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet E-1
Part I
Date/Time Prepared:
8/24/2015 1:06 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		36,787,650		16,352,207	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02		11/19/2014	226,576	11/19/2014	67,213	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		03/24/2015	3,095	03/24/2015	282,815	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)		223,481		-215,602	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)		37,011,131		16,136,605	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		692,661		212,886	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		37,703,792		16,349,491	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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet E-1 Part II Date/Time Prepared: 8/24/2015 1:06 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD 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			10,516 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			14,726 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			2,815 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			34,825 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			723,709,076 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			17,427,064 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)			1,499,297 8.00
9.00	Sequestration adjustment amount (see instructions)			29,986 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,469,311 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,443,040 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)			26,271 32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0 108.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet E-4 Date/Time Prepared: 8/24/2015 1:06 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			15.80	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			15.80	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			15.98	6.00
7.00	Enter the lesser of line 5 or line 6			15.80	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	15.98	0.00	15.98	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	15.80	0.00	15.80	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	15.80	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	15.49	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	15.32	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	15.54	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	15.54	0.00		17.00
18.00	Per resident amount	80,339.23	0.00		18.00
19.00	Approved amount for resident costs	1,248,472	0	1,248,472	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.18	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,248,472	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	14,737	2,815		26.00
27.00	Total Inpatient Days (see instructions)	35,837	35,837		27.00
28.00	Ratio of inpatient days to total inpatient days	0.411223	0.078550		28.00
29.00	Program direct GME amount	513,400	98,067		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		13,857		30.00
31.00	Net Program direct GME amount			597,610	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet E-4 Date/Time Prepared: 8/24/2015 1:06 pm
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		43,138,378	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		26,615	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		43,111,763	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		23,217,587	42.00
43.00	Primary payer payments (see instructions)		646	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		23,216,941	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		66,328,704	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.649971	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.350029	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		597,610	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		388,429	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		209,181	50.00

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

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet G
Date/Time Prepared:
8/24/2015 1:06 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	4,612,607	0	0	0	1.00
2.00	Temporary investments	25,415	0	17,661	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	188,491,767	0	0	0	4.00
5.00	Other receivable	219,605	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-136,460,689	0	0	0	6.00
7.00	Inventory	6,530,877	0	0	0	7.00
8.00	Prepaid expenses	1,002,623	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)	64,422,205	0	17,661	0	11.00
FIXED ASSETS						
12.00	Land	5,957,499	0	0	0	12.00
13.00	Land improvements	5,202,499	0	0	0	13.00
14.00	Accumulated depreciation	-2,664,710	0	0	0	14.00
15.00	Buildings	130,196,407	0	0	0	15.00
16.00	Accumulated depreciation	-67,553,912	0	0	0	16.00
17.00	Leasehold improvements	163,698	0	0	0	17.00
18.00	Accumulated depreciation	-103,622	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	678,713	0	0	0	21.00
22.00	Accumulated depreciation	-290,071	0	0	0	22.00
23.00	Major movable equipment	62,937,786	0	0	0	23.00
24.00	Accumulated depreciation	-41,532,846	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	18,285,169	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	111,276,610	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	245,610,061	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	167,810	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	245,777,871	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	421,476,686	0	17,661	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	10,010,448	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,267,588	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,205,940	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	5,189,084	0	0	0	43.00
44.00	Other current liabilities	1,891,274	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	27,564,334	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	105,691,105	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	11,853,314	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	117,544,419	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	145,108,753	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	276,367,933	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	17,661	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	276,367,933	0	17,661	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	421,476,686	0	17,661	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet G-1

Date/Time Prepared:
8/24/2015 1:06 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		253,499,939		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		22,867,950				2.00
3.00	Total (sum of line 1 and line 2)		276,367,889		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	ROUNDING	44		0		0	5.00
6.00	RESTRICTED GRANTS	0		0		369,489	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		44		0		10.00
11.00	Subtotal (line 3 plus line 10)		276,367,933		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00	GRANT PURCHASES	0		0		371,759	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		276,367,933		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	19,931		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)	19,931		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	ROUNDING		0				5.00
6.00	RESTRICTED GRANTS		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)	369,489		0			10.00
11.00	Subtotal (line 3 plus line 10)	389,420		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00	GRANT PURCHASES		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)	371,759		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	17,661		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet G-2
Parts I & II
Date/Time Prepared:
8/24/2015 1:06 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	42,206,635		42,206,635	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	42,206,635		42,206,635	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,396,242		5,396,242	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	NEONATAL INTENSIVE CARE UNIT	8,182,763		8,182,763	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	13,579,005		13,579,005	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	55,785,640		55,785,640	17.00
18.00	Ancillary services	282,804,762	393,724,784	676,529,546	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	1,278,933	1,278,933	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	338,590,402	395,003,717	733,594,119	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		195,190,093		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)		195,190,093		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140164

Period:
From 04/01/2014
To 03/31/2015

Worksheet G-3

Date/Time Prepared:
8/24/2015 1:06 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	733,594,119	1.00
2.00	Less contractual allowances and discounts on patients' accounts	495,356,721	2.00
3.00	Net patient revenues (line 1 minus line 2)	238,237,398	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	195,190,093	4.00
5.00	Net income from service to patients (line 3 minus line 4)	43,047,305	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	638	6.00
7.00	Income from investments	10,512,008	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	14,289	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	991,893	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	3,719	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	89,413	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	19,981	21.00
22.00	Rental of hospital space	560,905	22.00
23.00	Governmental appropriations	2,055,688	23.00
24.00	MISCELLANEOUS	61,696	24.00
25.00	Total other income (sum of lines 6-24)	14,310,230	25.00
26.00	Total (line 5 plus line 25)	57,357,535	26.00
27.00	CORP ALLOC/CONTR/LOSS ON EQUIPMENT	34,489,585	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	34,489,585	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	22,867,950	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet L Parts I-III Date/Time Prepared: 8/24/2015 1:06 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,517,591	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		97,250	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)		98.18	3.00
4.00	Number of interns & residents (see instructions)		12.17	4.00
5.00	Indirect medical education percentage (see instructions)		3.56	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		89,626	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		7.33	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		28.96	8.00
9.00	Sum of lines 7 and 8		36.29	9.00
10.00	Allowable disproportionate share percentage (see instructions)		7.63	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		192,092	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		2,896,559	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

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2014 To 03/31/2015	Worksheet M-1 Date/Time Prepared: 8/24/2015 1:06 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	109,173	0	109,173	0	109,173	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	38,837	0	38,837	0	38,837	9.00
10.00	Subtotal (sum of lines 1 through 9)	148,010	0	148,010	0	148,010	10.00
11.00	Physician Services Under Agreement	537,834	0	537,834	0	537,834	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	213,851	0	213,851	0	213,851	13.00
14.00	Subtotal (sum of lines 11 through 13)	751,685	0	751,685	0	751,685	14.00
15.00	Medical Supplies	0	79,037	79,037	-16,787	62,250	15.00
16.00	Transportation (Health Care Staff)	0	2,215	2,215	0	2,215	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	81,252	81,252	-16,787	64,465	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	899,695	81,252	980,947	-16,787	964,160	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	144,036	144,036	0	144,036	29.00
30.00	Administrative Costs	257,102	56,289	313,391	0	313,391	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	257,102	200,325	457,427	0	457,427	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,156,797	281,577	1,438,374	-16,787	1,421,587	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2014 To 03/31/2015	Worksheet M-1 Date/Time Prepared: 8/24/2015 1:06 pm
		Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	0
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	0
4.00	Visiting Nurse	0	109,173
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	38,837
10.00	Subtotal (sum of lines 1 through 9)	0	148,010
11.00	Physician Services Under Agreement	0	537,834
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	213,851
14.00	Subtotal (sum of lines 11 through 13)	0	751,685
15.00	Medical Supplies	0	62,250
16.00	Transportation (Health Care Staff)	0	2,215
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	64,465
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	964,160
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	144,036
30.00	Administrative Costs	-38,088	275,303
31.00	Total Facility Overhead (sum of lines 29 and 30)	-38,088	419,339
32.00	Total facility costs (sum of lines 22, 28 and 31)	-38,088	1,383,499

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2014 To 03/31/2015	Worksheet M-2 Date/Time Prepared: 8/24/2015 1:06 pm
			Rural Health Clinic (RHC) I	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.00	0	4,200	0	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.00	0	2,100	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.00	0		0	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.00	0		0	8.00
9.00	Physician Services Under Agreements		11,010			9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES			
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	964,160	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	964,160	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)	419,339	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	682,841	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,102,180	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	1,102,180	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,102,180	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	2,066,340	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140164	Period: From 04/01/2014 To 03/31/2015	Worksheet M-3
		Component CCN: 143454		Date/Time Prepared: 8/24/2015 1:06 pm
		Title XVIIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		2,066,340	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		9,505	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,056,835	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		0	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		11,010	5.00
6.00	Total adjusted visits (line 4 plus line 5)		11,010	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		186.82	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	79.80	80.44	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	2,112	570	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	168,538	45,851	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		214,389	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		146,339	16.04
16.05	Total program cost (see instructions)		146,339	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		31,465	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		146,339	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,107	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		149,446	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		149,446	26.00
26.01	Sequestration adjustment (see instructions)		2,989	26.01
27.00	Interim payments		146,939	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		-482	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2014 To 03/31/2015	Worksheet M-4 Date/Time Prepared: 8/24/2015 1:06 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	148,010	148,010	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.006905	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	1,022	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	3,413	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	4,435	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	964,160	964,160	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	1,102,180	1,102,180	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.004600	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	5,070	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	9,505	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	312	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	30.46	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	102	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	3,107	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		9,505	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		3,107	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2014 To 03/31/2015	Worksheet M-5 Date/Time Prepared: 8/24/2015 1:06 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		141,776	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	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	3.01
3.02		11/21/2014	9,804	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51		03/24/2015	4,641	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		5,163	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		146,939	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	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		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	6.01
6.02	SETTLEMENT TO PROGRAM		482	6.02
7.00	Total Medicare program liability (see instructions)		146,457	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00