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: 140184	Period: From 05/01/2014 To 04/30/2015	Worksheet S Parts I-III Date/Time Prepared: 9/25/2015 7:18 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/25/2015 Time: 7:18 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARION MEMORIAL HOSPITAL (140184) for the cost reporting period beginning 05/01/2014 and ending 04/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-369,017	-64,762	-161,884	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
200.00	Total	0	-369,017	-64,762	-161,884	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 9/25/2015 7:15 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 917 WEST MAIN ST	PO Box:			1.00
2.00	City: MARION	State: IL	Zip Code: 62959	County: WILLIAMSON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	MARION MEMORIAL HOSPITAL	140184	16060	1	07/01/1996	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	MARION MEMORIAL HOSPITAL	14U184	16060		03/23/1999	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
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)	05/01/2014	04/30/2015	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3,963	877	0	7	28	256	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: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/25/2015 7:15 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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.	1		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.	05/01/2014	09/30/2014	38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/25/2015 7:15 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140184	Period: From 05/01/2014 To 04/30/2015	Worksheet S-2 Part I Date/Time Prepared: 9/25/2015 7:15 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/25/2015 7:15 am

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	69,997	5,012,203	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: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 9/25/2015 7:15 am

		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	449008	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: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD.	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	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.	Y	145.00

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.75	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140184	Period: From 05/01/2014 To 04/30/2015	Worksheet S-2 Part I Date/Time Prepared: 9/25/2015 7:15 am

		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)	04/01/2014	06/30/2014	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. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 9/25/2015 7:15 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y			3.00
			Y/N	Type	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N			5.00
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.			N		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	
					1.00	
	Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N	14.00
	Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				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	08/17/2015	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: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 9/25/2015 7:15 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				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.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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.				N	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.	Y	12/31/2014	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.	MICHAEL	TEA	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-628-6555	MICHAEL_TEA@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 9/25/2015 7:15 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	08/17/2015			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.		REVENUE MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 9/25/2015 7:15 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	80	29,200	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)		80	29,200	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	18	6,570	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		98	35,770	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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		98				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 9/25/2015 7:15 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,444	2,967	12,299			1.00
2.00	HMO and other (see instructions)	604	559				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,444	2,967	12,299			7.00
8.00	INTENSIVE CARE UNIT	1,048	182	1,886			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1,423	1,645			13.00
14.00	Total (see instructions)	6,492	4,572	15,830	0.00	430.01	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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	430.01	27.00
28.00	Observation Bed Days		0	2,016			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 9/25/2015 7:15 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,680	1,643	4,803	1.00
2.00	HMO and other (see instructions)			161	0		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	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,680	1,643	4,803	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						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: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 9/25/2015 7:15 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	22,909,167	0	22,909,167	894,417.00	25.61	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		110,574	20,359	130,933	3,864.00	33.89	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		503,514	0	503,514	15,546.00	32.39	11.00
12.00	Contract labor: Top level management and other management and administrative services		48,791	0	48,791	522.00	93.47	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		1,816,485	0	1,816,485	34,026.00	53.39	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)		6,171,805	0	6,171,805			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		30,348	0	30,348			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	205,929	0	205,929	6,753.00	30.49	26.00
27.00	Administrative & General	5.00	2,720,812	775,072	3,495,884	119,887.00	29.16	27.00
28.00	Administrative & General under contract (see inst.)		303,874	0	303,874	2,886.25	105.28	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	343,467	0	343,467	13,886.00	24.73	30.00
31.00	Laundry & Linen Service	8.00	40,398	0	40,398	3,061.00	13.20	31.00
32.00	Housekeeping	9.00	820,680	0	820,680	67,193.00	12.21	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	667,912	-242,596	425,316	33,089.85	12.85	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	242,596	242,596	18,874.15	12.85	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,524,922	-852,208	672,714	14,455.00	46.54	38.00
39.00	Central Services and Supply	14.00	142,668	0	142,668	11,895.00	11.99	39.00
40.00	Pharmacy	15.00	966,260	0	966,260	22,924.00	42.15	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 9/25/2015 7:15 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	393,624	0	393,624	25,743.00	15.29	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: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 9/25/2015 7:15 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		23,213,041	0	23,213,041	897,303.25	25.87	1.00
2.00	Excluded area salaries (see instructions)		110,574	20,359	130,933	3,864.00	33.89	2.00
3.00	Subtotal salaries (line 1 minus line 2)		23,102,467	-20,359	23,082,108	893,439.25	25.84	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,368,790	0	2,368,790	50,094.00	47.29	4.00
5.00	Subtotal wage-related costs (see inst.)		6,171,805	0	6,171,805	0.00	26.74	5.00
6.00	Total (sum of lines 3 thru 5)		31,643,062	-20,359	31,622,703	943,533.25	33.52	6.00
7.00	Total overhead cost (see instructions)		8,130,546	-77,136	8,053,410	340,647.25	23.64	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part IV Date/Time Prepared: 9/25/2015 7:15 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	325,892	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,148,906	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	33,367	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	18,749	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-66	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	9,546	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	633,606	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,340,384	17.00
18.00	Medicare Taxes - Employers Portion Only	313,477	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	215,146	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	163,145	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,202,152	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part V Date/Time Prepared: 9/25/2015 7:15 am

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-10 | Date/Time Prepared: 9/25/2015 7:15 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.122427	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	9,416,913	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	6,650,534	5.00
6.00	Medicaid charges	148,511,753	6.00
7.00	Medicaid cost (line 1 times line 6)	18,181,848	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)	2,114,401	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	3,343	9.00
10.00	Stand-alone SCHIP charges	40,361	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	4,941	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	1,598	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,115,999	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	333,621	60,458	394,079	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	40,844	7,402	48,246	21.00
22.00	Partial payment by patients approved for charity care	350	0	350	22.00
23.00	Cost of charity care (line 21 minus line 22)	40,494	7,402	47,896	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	5,016,037	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	236,020	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,780,017	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	585,203	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	633,099	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,749,098	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,152,499	1,152,499	2,097,641	3,250,140	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,122,735	4,122,735	1,054,016	5,176,751	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	205,929	148,219	354,148	4,245,752	4,599,900	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,720,812	16,250,431	18,971,243	-5,837,832	13,133,411	5.00
7.00	00700	OPERATION OF PLANT	343,467	1,925,772	2,269,239	0	2,269,239	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	40,398	281,394	321,792	0	321,792	8.00
9.00	00900	HOUSEKEEPING	820,680	292,159	1,112,839	0	1,112,839	9.00
10.00	01000	DIETARY	667,912	833,483	1,501,395	-545,065	956,330	10.00
11.00	01100	CAFETERIA	0	0	0	545,065	545,065	11.00
13.00	01300	NURSING ADMINISTRATION	1,524,922	252,596	1,777,518	-978,263	799,255	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	142,668	6,260,388	6,403,056	-6,000,521	402,535	14.00
15.00	01500	PHARMACY	966,260	3,816,821	4,783,081	-3,702,148	1,080,933	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	393,624	810,471	1,204,095	0	1,204,095	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,468,067	1,667,210	5,135,277	-240,624	4,894,653	30.00
31.00	03100	INTENSIVE CARE UNIT	1,374,298	257,335	1,631,633	-802	1,630,831	31.00
43.00	04300	NURSERY	232,813	64,487	297,300	159,548	456,848	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,409,251	3,253,796	4,663,047	-54,249	4,608,798	50.00
51.00	05100	RECOVERY ROOM	321,105	39,087	360,192	-360,192	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,004,503	101,030	1,105,533	71,494	1,177,027	52.00
53.00	05300	ANESTHESIOLOGY	0	4,385,605	4,385,605	-248	4,385,357	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,660,125	1,808,683	3,468,808	-190,901	3,277,907	54.00
54.01	05401	ULTRASOUND	161,081	74,284	235,365	-58,401	176,964	54.01
56.00	05600	RADIOISOTOPE	147,112	328,710	475,822	0	475,822	56.00
57.00	05700	CT SCAN	215,919	62,942	278,861	0	278,861	57.00
58.00	05800	MRI	69,843	11,293	81,136	0	81,136	58.00
60.00	06000	LABORATORY	962,011	2,247,930	3,209,941	-850,306	2,359,635	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	794,848	794,848	62.00
65.00	06500	RESPIRATORY THERAPY	493,145	174,338	667,483	-59,257	608,226	65.00
66.00	06600	PHYSICAL THERAPY	579,532	131,852	711,384	-41,474	669,910	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,224	11,470	138,694	0	138,694	67.00
68.00	06800	SPEECH PATHOLOGY	69,297	5,441	74,738	0	74,738	68.00
69.00	06900	ELECTROCARDIOLOGY	1,045,055	1,997,630	3,042,685	-414,596	2,628,089	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,481,568	1,481,568	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,928,315	4,928,315	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,595,850	3,595,850	73.00
74.00	07400	RENAL DIALYSIS	0	233,439	233,439	0	233,439	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	216,939	216,939	0	216,939	76.01
76.03	03951	WOUND CARE	191,003	120,513	311,516	-19,945	291,571	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,440,537	2,009,493	3,450,030	198,667	3,648,697	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	56,777	141,890	198,667	-198,667	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,855,370	55,492,365	78,347,735	-380,727	77,967,008	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3	3	0	3	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	53,797	11,629	65,426	0	65,426	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	380,727	380,727	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	22,909,167	55,503,997	78,413,164	0	78,413,164	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	597,297	3,847,437		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-952,107	4,224,644		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,736	4,597,164		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,102,437	14,235,848		5.00
7.00	00700	OPERATION OF PLANT	-12,591	2,256,648		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	321,792		8.00
9.00	00900	HOUSEKEEPING	0	1,112,839		9.00
10.00	01000	DIETARY	0	956,330		10.00
11.00	01100	CAFETERIA	-410,278	134,787		11.00
13.00	01300	NURSING ADMINISTRATION	160	799,415		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	402,535		14.00
15.00	01500	PHARMACY	0	1,080,933		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,416	1,202,679		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-601,085	4,293,568		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,630,831		31.00
43.00	04300	NURSERY	0	456,848		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-920,347	3,688,451		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,177,027		52.00
53.00	05300	ANESTHESIOLOGY	-4,225,379	159,978		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-677,524	2,600,383		54.00
54.01	05401	ULTRASOUND	0	176,964		54.01
56.00	05600	RADIOISOTOPE	0	475,822		56.00
57.00	05700	CT SCAN	0	278,861		57.00
58.00	05800	MRI	0	81,136		58.00
60.00	06000	LABORATORY	0	2,359,635		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	794,848		62.00
65.00	06500	RESPIRATORY THERAPY	0	608,226		65.00
66.00	06600	PHYSICAL THERAPY	0	669,910		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	138,694		67.00
68.00	06800	SPEECH PATHOLOGY	0	74,738		68.00
69.00	06900	ELECTROCARDIOLOGY	-533,376	2,094,713		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-70	1,481,498		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,928,315		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-5,122	3,590,728		73.00
74.00	07400	RENAL DIALYSIS	0	233,439		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	-208,406	8,533		76.01
76.03	03951	WOUND CARE	0	291,571		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,397,529	2,251,168		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,248,072	69,718,936		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	SENIOR CIRCLE	0	65,426		193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0		194.00
194.01	07953	MARKETING	0	380,727		194.01
194.02	07952	NON ALLOWABLE MEALS	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-8,248,072	70,165,092		200.00

RECLASSIFICATIONS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-6 | Date/Time Prepared: 9/25/2015 7:15 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,245,752		1.00
	TOTALS		0	4,245,752		
	B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	46,243		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	46,243		
	C - RENTAL AND LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,164,289		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,048,453		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
	TOTALS		0	2,212,742		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	90,410		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	842,942		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,563		3.00
	TOTALS		0	938,915		
	E - MARKETING DEPARTMENT					
1.00	MARKETING	194.01	77,136	303,591		1.00
	TOTALS		77,136	303,591		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,435,325		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,928,315		2.00
3.00	OPERATING ROOM	50.00	0	52,830		3.00
	TOTALS		0	6,416,470		
	G - DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,595,850		1.00
	TOTALS		0	3,595,850		
	H - LABOR AND DELIVERY COSTS					
1.00	NURSERY	43.00	102,901	56,647		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	131,456		2.00
	TOTALS		102,901	188,103		
	J - NURSING ADMIN COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	852,208	126,055		1.00
	TOTALS		852,208	126,055		
	K - MISCELLANEOUS DEPARTMENTS					
1.00	OPERATING ROOM	50.00	321,105	39,087		1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	52,956	741,892		2.00
3.00	EMERGENCY	91.00	56,777	141,890		3.00
	TOTALS		430,838	922,869		
	M - PORTION OF DIETARY COST TO CAFETERIA					
1.00	CAFETERIA	11.00	242,596	302,469		1.00
	TOTALS		242,596	302,469		
500.00	Grand Total: Increases		1,705,679	19,299,059		500.00

RECLASSIFICATIONS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-6 | Date/Time Prepared: 9/25/2015 7:15 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,245,752	0		1.00
	TOTALS		0	4,245,752			
	B - OXYGEN COSTS						
1.00	RESPIRATORY THERAPY	65.00	0	34,585	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	261	0		2.00
3.00	WOUND CARE	76.03	0	11,397	0		3.00
	TOTALS		0	46,243			
	C - RENTAL AND LEASES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,250,701	10		1.00
2.00	PHARMACY	15.00	0	106,298	10		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	9,582	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	802	0		4.00
5.00	OPERATING ROOM	50.00	0	467,271	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	248	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	190,901	0		7.00
8.00	ULTRASOUND	54.01	0	58,401	0		8.00
9.00	LABORATORY	60.00	0	55,458	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	22,953	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	41,474	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	105	0		12.00
13.00	WOUND CARE	76.03	0	8,548	0		13.00
	TOTALS		0	2,212,742			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	938,915	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	938,915			
	E - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	77,136	303,591	0		1.00
	TOTALS		77,136	303,591			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	6,000,521	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	1,719	0		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	414,230	0		3.00
	TOTALS		0	6,416,470			
	G - DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	3,595,850	0		1.00
	TOTALS		0	3,595,850			
	H - LABOR AND DELIVERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	42,939	188,103	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	59,962	0	0		2.00
	TOTALS		102,901	188,103			
	J - NURSING ADMIN COSTS						
1.00	NURSING ADMINISTRATION	13.00	852,208	126,055	0		1.00
	TOTALS		852,208	126,055			
	K - MISCELLANEOUS DEPARTMENTS						
1.00	RECOVERY ROOM	51.00	321,105	39,087	0		1.00
2.00	LABORATORY	60.00	52,956	741,892	0		2.00
3.00	AMBULANCE SERVICES	95.00	56,777	141,890	0		3.00
	TOTALS		430,838	922,869			
	M - PORTION OF DIETARY COST TO CAFETERIA						
1.00	DIETARY	10.00	242,596	302,469	0		1.00
	TOTALS		242,596	302,469			
500.00	Grand Total: Decreases		1,705,679	19,299,059			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 9/25/2015 7:15 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,393,860	0	0	0	0	1.00
2.00	Land Improvements	562,648	0	0	0	0	2.00
3.00	Buildings and Fixtures	46,966,867	7,927	0	7,927	0	3.00
4.00	Building Improvements	3,090,942	384,068	0	384,068	0	4.00
5.00	Fixed Equipment	2,282,249	12,089	0	12,089	15,815	5.00
6.00	Movable Equipment	24,643,261	1,578,997	0	1,578,997	1,756,841	6.00
7.00	HIT designated Assets	6,323,263	232,998	0	232,998	0	7.00
8.00	Subtotal (sum of lines 1-7)	85,263,090	2,216,079	0	2,216,079	1,772,656	8.00
9.00	Reconciling Items	-365,710	-48,474	0	-48,474	-301,329	9.00
10.00	Total (line 8 minus line 9)	85,628,800	2,264,553	0	2,264,553	2,073,985	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,393,860	0	1.00
2.00	Land Improvements	562,648	0	2.00
3.00	Buildings and Fixtures	46,974,794	0	3.00
4.00	Building Improvements	3,475,010	0	4.00
5.00	Fixed Equipment	2,278,523	0	5.00
6.00	Movable Equipment	24,465,417	0	6.00
7.00	HIT designated Assets	6,556,261	0	7.00
8.00	Subtotal (sum of lines 1-7)	85,706,513	0	8.00
9.00	Reconciling Items	-112,855	0	9.00
10.00	Total (line 8 minus line 9)	85,819,368	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 9/25/2015 7:15 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,152,499	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,122,735	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,275,234	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	1,152,499		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,122,735		2.00
3.00	Total (sum of lines 1-2)	0	5,275,234		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 9/25/2015 7:15 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	52,406,313	0	52,406,313	0.611462	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	33,300,201	0	33,300,201	0.388538	0	2.00
3.00	Total (sum of lines 1-2)	85,706,514	0	85,706,514	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	1,522,955	1,146,318	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,084,265	1,048,453	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,607,220	2,194,771	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	244,812	90,410	842,942	0	3,847,437	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	86,363	5,563	0	0	4,224,644	2.00
3.00	Total (sum of lines 1-2)	331,175	95,973	842,942	0	8,072,081	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8 | Date/Time Prepared: 9/25/2015 7:15 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		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)	B	-17,971	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	B	-38,425	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-8,476,217			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-2,150	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	14,264,401			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-410,278	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	B	-70	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-5,122	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,416	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	B	160	NURSING ADMINISTRATION	13.00	0	19.00
20.00	Vending machines	B	-4,178	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	366,367	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,038,423	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS REVENUE	A	-24,928	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	EMPLOYEE GIFTS	A	-30,151	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8 | Date/Time Prepared: 9/25/2015 7:15 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	HOSPITAL BAD DEBT	A	-6,827,040	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PATIENT PHONE BENEFIT EXPENSE	A	-2,736	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	PATIENT PHONE DEPRECIATION EXPENSE	A	-5,371	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.04
33.05	PATIENT TV DEPRECIATION EXPENSE	A	-23,716	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06	MARKETING EXPENSES	A	-178,607	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	DOJ SETTLEMENT	A	-1,822,149	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	PHYSICIAN RECRUITING	A	-267,056	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	LOBBYING EXPENSE	A	-49,582	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	CHARITABLE CONTRIBUTIONS	A	-21,738	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	GIFT SHOP	A	-1,138	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	ILLINOIS PROVIDER TAX	A	-3,494,312	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	CRNA COST	A	-85,279	ANESTHESIOLOGY	53.00	0	33.13
33.14	LEGAL COSTS	A	-55,544	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	PENALTIES/LATE CHARGES	A	-2,386	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	SPECIAL EVENTS	A	-1,575	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	POLITICAL CONTRIBUTIONS	A	-9,763	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	LATE CHARGES	A	31,032	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	PATIENT TV CABLE EXPENSE	A	-12,591	OPERATION OF PLANT	7.00	0	33.19
33.20	TELEVISION RENTAL	B	-120	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21			0		0.00	0	33.21
33.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.22
33.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,248,072				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: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 9/25/2015 7:15 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL RELAT INTEREST	194,554	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	524,635	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS	33,521	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAP BLDG & FIXTURES	16,737	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL MOVEABLE EQUIP	111,115	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	NON CAPITAL HOME OFFICE COST	1,603,071	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	5,082,200	226,569	4.03
4.04	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	58,025	82,777	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	-10,073,717	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	1,051,448	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	3,296	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	56,991	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	MIS FEES	0	457,004	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	MANAGED CARE	0	26,081	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	CASE MANAGEMENT	0	123,458	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	PURCHASE AND ANCILLARY	0	7,100	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	EMERGENCY ROOM	0	73,853	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	24,420	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	COMPLIANCE/HIM/CCA FEES	0	32,861	4.15
4.16	5.00	ADMINISTRATIVE & GENERAL	SENIOR CIRCLE	0	20,919	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	PASI COLLECTION FEES	0	606,812	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	EBOS FEES	0	82,121	4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN COLLECTION FEES	0	102,631	4.19
4.20	1.00	CAP REL COSTS-BLDG & FIXT	PRE-ACQUISITION LEGACY COSTS	4,089	0	4.20
4.21	2.00	CAP REL COSTS-MVBLE EQUIP	PRE-ACQUISITION LEGACY COSTS	24,143	0	4.21
4.22	5.00	ADMINISTRATIVE & GENERAL	PRE-ACQUISITION LEGACY COSTS	250,851	0	4.22
4.23	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS	4,897	0	4.23
4.24	5.00	ADMINISTRATIVE & GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	738,813	4.24
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,907,838	-6,356,563	5.00

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

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

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

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

6.00	B		0.00	CHS, INC	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140184	Period: From 05/01/2014 To 04/30/2015	Worksheet A-8-1 Date/Time Prepared: 9/25/2015 7:15 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	194,554	11		1.00
2.00	524,635	0		2.00
3.00	33,521	11		3.00
4.00	16,737	11		4.00
4.01	111,115	11		4.01
4.02	1,603,071	0		4.02
4.03	4,855,631	0		4.03
4.04	-24,752	11		4.04
4.05	10,073,717	0		4.05
4.06	-1,051,448	0		4.06
4.07	-3,296	0		4.07
4.08	-56,991	0		4.08
4.09	-457,004	0		4.09
4.10	-26,081	0		4.10
4.11	-123,458	0		4.11
4.12	-7,100	0		4.12
4.13	-73,853	0		4.13
4.14	-24,420	0		4.14
4.15	-32,861	0		4.15
4.16	-20,919	0		4.16
4.17	-606,812	0		4.17
4.18	-82,121	0		4.18
4.19	-102,631	0		4.19
4.20	4,089	9		4.20
4.21	24,143	9		4.21
4.22	250,851	0		4.22
4.23	4,897	9		4.23
4.24	-738,813	0		4.24
5.00	14,264,401			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	HOSPITAL CORPOR		6.00
7.00	COLLECTION AGEN		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 9/25/2015 7:15 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	601,085	601,085	0	0	0	1.00
2.00	50.00	OPERATING ROOM	920,347	920,347	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	4,140,100	4,140,100	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	675,374	675,374	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	533,376	533,376	0	0	0	5.00
6.00	76.01	SLEEP LAB	208,406	208,406	0	0	0	6.00
7.00	91.00	EMERGENCY	1,397,529	1,397,529	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			8,476,217	8,476,217	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	76.01	SLEEP LAB	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	601,085		1.00
2.00	50.00	OPERATING ROOM	0	0	0	920,347		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	4,140,100		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	675,374		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	533,376		5.00
6.00	76.01	SLEEP LAB	0	0	0	208,406		6.00
7.00	91.00	EMERGENCY	0	0	0	1,397,529		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	8,476,217		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,847,437	3,847,437				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,224,644		4,224,644			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,597,164	19,747	21,683	4,638,594		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,235,848	389,790	428,005	714,263	15,767,906	5.00
7.00	00700	OPERATION OF PLANT	2,256,648	836,209	918,189	70,175	4,081,221	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	321,792	8,108	8,903	8,254	347,057	8.00
9.00	00900	HOUSEKEEPING	1,112,839	21,986	24,142	167,676	1,326,643	9.00
10.00	01000	DIETARY	956,330	59,911	65,785	86,898	1,168,924	10.00
11.00	01100	CAFETERIA	134,787	67,709	74,347	49,566	326,409	11.00
13.00	01300	NURSING ADMINISTRATION	799,415	93,340	102,492	137,445	1,132,692	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	402,535	38,104	41,840	29,149	511,628	14.00
15.00	01500	PHARMACY	1,080,933	34,655	38,053	197,420	1,351,061	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,202,679	56,070	61,567	80,423	1,400,739	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,293,568	604,702	663,987	699,802	6,262,059	30.00
31.00	03100	INTENSIVE CARE UNIT	1,630,831	200,150	219,773	280,788	2,331,542	31.00
43.00	04300	NURSERY	456,848	32,465	35,648	68,591	593,552	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,688,451	335,584	368,485	353,536	4,746,056	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,177,027	78,301	85,978	192,983	1,534,289	52.00
53.00	05300	ANESTHESIOLOGY	159,978	9,726	10,680	0	180,384	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,600,383	119,168	130,852	339,187	3,189,590	54.00
54.01	05401	ULTRASOUND	176,964	34,099	37,443	32,911	281,417	54.01
56.00	05600	RADIOISOTOPE	475,822	11,296	12,403	30,057	529,578	56.00
57.00	05700	CT SCAN	278,861	19,649	21,575	44,115	364,200	57.00
58.00	05800	MRI	81,136	20,875	22,921	14,270	139,202	58.00
60.00	06000	LABORATORY	2,359,635	77,451	85,045	185,733	2,707,864	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	794,848	4,119	4,523	10,820	814,310	62.00
65.00	06500	RESPIRATORY THERAPY	608,226	17,736	19,475	100,756	746,193	65.00
66.00	06600	PHYSICAL THERAPY	669,910	106,990	117,479	118,407	1,012,786	66.00
67.00	06700	OCCUPATIONAL THERAPY	138,694	2,697	2,962	25,994	170,347	67.00
68.00	06800	SPEECH PATHOLOGY	74,738	1,520	1,669	14,158	92,085	68.00
69.00	06900	ELECTROCARDIOLOGY	2,094,713	68,493	75,208	213,519	2,451,933	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,481,498	0	0	0	1,481,498	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,928,315	0	0	0	4,928,315	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,590,728	0	0	0	3,590,728	73.00
74.00	07400	RENAL DIALYSIS	233,439	5,460	5,995	0	244,894	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	8,533	38,513	42,289	0	89,335	76.01
76.03	03951	WOUND CARE	291,571	46,000	50,510	39,025	427,106	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,251,168	155,916	171,202	305,922	2,884,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,718,936	3,616,539	3,971,108	4,611,843	69,207,751	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,050	12,134	0	23,184	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3	215,778	236,933	0	452,714	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	65,426	4,070	4,469	10,991	84,956	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	380,727	0	0	15,760	396,487	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
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)	70,165,092	3,847,437	4,224,644	4,638,594	70,165,092	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,767,906					5.00
7.00	00700	OPERATION OF PLANT	1,183,007	5,264,228				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	100,600	16,406	464,063			8.00
9.00	00900	HOUSEKEEPING	384,549	44,487	0	1,755,679		9.00
10.00	01000	DIETARY	338,831	121,223	0	40,902	1,669,880	10.00
11.00	01100	CAFETERIA	94,615	137,000	0	46,226	987,799	11.00
13.00	01300	NURSING ADMINISTRATION	328,329	188,863	0	63,725	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	148,304	77,100	0	26,015	0	14.00
15.00	01500	PHARMACY	391,627	70,121	0	23,660	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	406,027	113,450	0	38,280	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,815,168	1,223,545	137,162	412,841	387,629	30.00
31.00	03100	INTENSIVE CARE UNIT	675,835	404,981	31,090	136,646	59,438	31.00
43.00	04300	NURSERY	172,051	65,689	0	22,164	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,375,720	679,015	78,182	229,109	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	444,738	158,434	67,209	53,458	0	52.00
53.00	05300	ANESTHESIOLOGY	52,287	19,680	5,944	6,640	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	924,554	241,123	21,946	81,358	0	54.00
54.01	05401	ULTRASOUND	81,573	68,996	0	23,280	0	54.01
56.00	05600	RADIOISOTOPE	153,507	22,855	0	7,712	0	56.00
57.00	05700	CT SCAN	105,569	39,757	0	13,415	0	57.00
58.00	05800	MRI	40,350	42,238	0	14,252	0	58.00
60.00	06000	LABORATORY	784,918	156,714	0	52,877	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	236,041	8,335	0	2,812	0	62.00
65.00	06500	RESPIRATORY THERAPY	216,296	35,887	0	12,109	0	65.00
66.00	06600	PHYSICAL THERAPY	293,572	216,482	7,772	73,044	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,378	5,458	0	1,841	0	67.00
68.00	06800	SPEECH PATHOLOGY	26,692	3,076	0	1,038	0	68.00
69.00	06900	ELECTROCARDIOLOGY	710,732	138,588	26,975	46,762	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	429,436	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,428,551	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,040,830	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	70,986	11,047	0	3,728	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	25,895	77,927	2,743	26,294	0	76.01
76.03	03951	WOUND CARE	123,804	93,076	914	31,405	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	836,034	315,478	83,669	106,447	9,656	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,490,406	4,797,031	463,606	1,598,040	1,444,522	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,720	22,359	0	7,544	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	131,226	436,602	457	147,316	973	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	24,626	8,236	0	2,779	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	114,928	0	0	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	224,385	194.02
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)	15,767,906	5,264,228	464,063	1,755,679	1,669,880	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,592,049					11.00
13.00	01300	NURSING ADMINISTRATION	36,434	1,750,043				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	29,986	0	793,033			14.00
15.00	01500	PHARMACY	57,771	0	2,155	1,896,395		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	64,900	0	919	0	2,024,315	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	336,978	451,002	45,617	0	146,708	30.00
31.00	03100	INTENSIVE CARE UNIT	102,173	180,961	9,178	0	29,957	31.00
43.00	04300	NURSERY	28,676	44,205	3,378	0	9,505	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	170,167	227,845	102,507	0	317,774	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	84,612	124,372	897	0	16,092	52.00
53.00	05300	ANESTHESIOLOGY	0	0	9,269	0	53,843	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,394	218,597	14,281	0	52,642	54.00
54.01	05401	ULTRASOUND	13,053	21,210	197	0	17,050	54.01
56.00	05600	RADIOISOTOPE	10,380	19,371	195	0	67,005	56.00
57.00	05700	CT SCAN	21,598	28,431	3,365	0	112,556	57.00
58.00	05800	MRI	6,029	9,197	418	0	22,991	58.00
60.00	06000	LABORATORY	127,232	0	44,648	0	279,913	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,662	0	2,821	0	18,035	62.00
65.00	06500	RESPIRATORY THERAPY	51,427	64,935	4,673	0	43,407	65.00
66.00	06600	PHYSICAL THERAPY	49,488	0	1,852	0	30,782	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,485	0	0	0	6,594	67.00
68.00	06800	SPEECH PATHOLOGY	4,299	0	11	0	2,906	68.00
69.00	06900	ELECTROCARDIOLOGY	95,568	137,608	32,900	0	254,166	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	106,352	0	47,274	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	365,170	0	123,817	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,896,395	170,903	73.00
74.00	07400	RENAL DIALYSIS	0	0	9	0	5,970	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	629	0	5,636	76.01
76.03	03951	WOUND CARE	18,925	25,150	3,803	0	5,048	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	117,062	197,159	37,716	0	183,741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,582,299	1,750,043	792,960	1,896,395	2,024,315	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	5,242	0	35	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	4,508	0	38	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
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)	1,592,049	1,750,043	793,033	1,896,395	2,024,315	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I | Date/Time Prepared: 9/25/2015 7:15 am

		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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	11,218,709	0	11,218,709		30.00
31.00	03100	INTENSIVE CARE UNIT	3,961,801	0	3,961,801		31.00
43.00	04300	NURSERY	939,220	0	939,220		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	7,926,375	0	7,926,375		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,484,101	0	2,484,101		52.00
53.00	05300	ANESTHESIOLOGY	328,047	0	328,047		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,883,485	0	4,883,485		54.00
54.01	05401	ULTRASOUND	506,776	0	506,776		54.01
56.00	05600	RADIOISOTOPE	810,603	0	810,603		56.00
57.00	05700	CT SCAN	688,891	0	688,891		57.00
58.00	05800	MRI	274,677	0	274,677		58.00
60.00	06000	LABORATORY	4,154,166	0	4,154,166		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,088,016	0	1,088,016		62.00
65.00	06500	RESPIRATORY THERAPY	1,174,927	0	1,174,927		65.00
66.00	06600	PHYSICAL THERAPY	1,685,778	0	1,685,778		66.00
67.00	06700	OCCUPATIONAL THERAPY	244,103	0	244,103		67.00
68.00	06800	SPEECH PATHOLOGY	130,107	0	130,107		68.00
69.00	06900	ELECTROCARDIOLOGY	3,895,232	0	3,895,232		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,064,560	0	2,064,560		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,845,853	0	6,845,853		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,698,856	0	6,698,856		73.00
74.00	07400	RENAL DIALYSIS	336,634	0	336,634		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	228,459	0	228,459		76.01
76.03	03951	WOUND CARE	729,231	0	729,231		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	4,771,170	0	4,771,170		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	68,069,777	0	68,069,777		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	59,807	0	59,807		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,169,288	0	1,169,288		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	SENIOR CIRCLE	125,874	0	125,874		193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0		194.00
194.01	07953	MARKETING	515,961	0	515,961		194.01
194.02	07952	NON ALLOWABLE MEALS	224,385	0	224,385		194.02
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)	70,165,092	0	70,165,092		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	19,747	21,683	41,430	41,430	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	389,790	428,005	817,795	6,376	5.00
7.00	00700	OPERATION OF PLANT	0	836,209	918,189	1,754,398	627	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,108	8,903	17,011	74	8.00
9.00	00900	HOUSEKEEPING	0	21,986	24,142	46,128	1,498	9.00
10.00	01000	DIETARY	0	59,911	65,785	125,696	776	10.00
11.00	01100	CAFETERIA	0	67,709	74,347	142,056	443	11.00
13.00	01300	NURSING ADMINISTRATION	0	93,340	102,492	195,832	1,228	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	38,104	41,840	79,944	260	14.00
15.00	01500	PHARMACY	0	34,655	38,053	72,708	1,763	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	56,070	61,567	117,637	718	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	604,702	663,987	1,268,689	6,251	30.00
31.00	03100	INTENSIVE CARE UNIT	0	200,150	219,773	419,923	2,508	31.00
43.00	04300	NURSERY	0	32,465	35,648	68,113	613	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	335,584	368,485	704,069	3,158	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	78,301	85,978	164,279	1,724	52.00
53.00	05300	ANESTHESIOLOGY	0	9,726	10,680	20,406	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	119,168	130,852	250,020	3,030	54.00
54.01	05401	ULTRASOUND	0	34,099	37,443	71,542	294	54.01
56.00	05600	RADIOISOTOPE	0	11,296	12,403	23,699	268	56.00
57.00	05700	CT SCAN	0	19,649	21,575	41,224	394	57.00
58.00	05800	MRI	0	20,875	22,921	43,796	127	58.00
60.00	06000	LABORATORY	0	77,451	85,045	162,496	1,659	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,119	4,523	8,642	97	62.00
65.00	06500	RESPIRATORY THERAPY	0	17,736	19,475	37,211	900	65.00
66.00	06600	PHYSICAL THERAPY	0	106,990	117,479	224,469	1,058	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,697	2,962	5,659	232	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,520	1,669	3,189	126	68.00
69.00	06900	ELECTROCARDIOLOGY	0	68,493	75,208	143,701	1,907	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	5,460	5,995	11,455	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	38,513	42,289	80,802	0	76.01
76.03	03951	WOUND CARE	0	46,000	50,510	96,510	349	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	155,916	171,202	327,118	2,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,616,539	3,971,108	7,587,647	41,191	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,050	12,134	23,184	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	215,778	236,933	452,711	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	4,070	4,469	8,539	98	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	141	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
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	3,847,437	4,224,644	8,072,081	41,430	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	824,171					5.00
7.00	00700	OPERATION OF PLANT	61,835	1,816,860				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,258	5,662	28,005			8.00
9.00	00900	HOUSEKEEPING	20,100	15,354	0	83,080		9.00
10.00	01000	DIETARY	17,710	41,838	0	1,936	187,956	10.00
11.00	01100	CAFETERIA	4,945	47,283	0	2,187	111,183	11.00
13.00	01300	NURSING ADMINISTRATION	17,161	65,183	0	3,016	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,752	26,610	0	1,231	0	14.00
15.00	01500	PHARMACY	20,470	24,201	0	1,120	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,223	39,155	0	1,811	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	94,876	422,285	8,277	19,537	43,630	30.00
31.00	03100	INTENSIVE CARE UNIT	35,325	139,773	1,876	6,466	6,690	31.00
43.00	04300	NURSERY	8,993	22,671	0	1,049	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	71,907	234,351	4,718	10,842	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,246	54,681	4,056	2,530	0	52.00
53.00	05300	ANESTHESIOLOGY	2,733	6,792	359	314	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,325	83,220	1,324	3,850	0	54.00
54.01	05401	ULTRASOUND	4,264	23,813	0	1,102	0	54.01
56.00	05600	RADIOISOTOPE	8,024	7,888	0	365	0	56.00
57.00	05700	CT SCAN	5,518	13,722	0	635	0	57.00
58.00	05800	MRI	2,109	14,578	0	674	0	58.00
60.00	06000	LABORATORY	41,027	54,087	0	2,502	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,338	2,877	0	133	0	62.00
65.00	06500	RESPIRATORY THERAPY	11,306	12,386	0	573	0	65.00
66.00	06600	PHYSICAL THERAPY	15,345	74,715	469	3,456	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,581	1,884	0	87	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,395	1,062	0	49	0	68.00
69.00	06900	ELECTROCARDIOLOGY	37,149	47,831	1,628	2,213	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,446	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	74,669	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	54,403	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,710	3,813	0	176	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,354	26,895	166	1,244	0	76.01
76.03	03951	WOUND CARE	6,471	32,123	55	1,486	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	43,699	108,882	5,049	5,037	1,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	809,667	1,655,615	27,977	75,621	162,590	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	351	7,717	0	357	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,859	150,686	28	6,971	110	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	1,287	2,842	0	131	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	6,007	0	0	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	25,256	194.02
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)	824,171	1,816,860	28,005	83,080	187,956	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	308,097					11.00
13.00	01300	NURSING ADMINISTRATION	7,051	289,471				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,803	0	121,600			14.00
15.00	01500	PHARMACY	11,180	0	330	131,772		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,560	0	141	0	193,245	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,212	74,601	6,995	0	14,022	30.00
31.00	03100	INTENSIVE CARE UNIT	19,773	29,932	1,407	0	2,863	31.00
43.00	04300	NURSERY	5,549	7,312	518	0	908	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,931	37,687	15,719	0	30,136	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,374	20,572	138	0	1,538	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,421	0	5,146	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,976	36,158	2,190	0	5,031	54.00
54.01	05401	ULTRASOUND	2,526	3,508	30	0	1,630	54.01
56.00	05600	RADIOISOTOPE	2,009	3,204	30	0	6,404	56.00
57.00	05700	CT SCAN	4,180	4,703	516	0	10,758	57.00
58.00	05800	MRI	1,167	1,521	64	0	2,197	58.00
60.00	06000	LABORATORY	24,622	0	6,846	0	26,754	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,096	0	433	0	1,724	62.00
65.00	06500	RESPIRATORY THERAPY	9,952	10,741	717	0	4,149	65.00
66.00	06600	PHYSICAL THERAPY	9,577	0	284	0	2,942	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,029	0	0	0	630	67.00
68.00	06800	SPEECH PATHOLOGY	832	0	2	0	278	68.00
69.00	06900	ELECTROCARDIOLOGY	18,495	22,761	5,045	0	24,293	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	16,308	0	4,518	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	55,992	0	11,834	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	131,772	16,335	73.00
74.00	07400	RENAL DIALYSIS	0	0	1	0	571	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	96	0	539	76.01
76.03	03951	WOUND CARE	3,662	4,160	583	0	483	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	22,654	32,611	5,783	0	17,562	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	306,210	289,471	121,589	131,772	193,245	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	1,015	0	5	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	872	0	6	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
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)	308,097	289,471	121,600	131,772	193,245	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/25/2015 7:15 am

		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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,024,375	0	2,024,375		30.00
31.00	03100	INTENSIVE CARE UNIT	666,536	0	666,536		31.00
43.00	04300	NURSERY	115,726	0	115,726		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,145,518	0	1,145,518		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	289,138	0	289,138		52.00
53.00	05300	ANESTHESIOLOGY	37,171	0	37,171		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	460,124	0	460,124		54.00
54.01	05401	ULTRASOUND	108,709	0	108,709		54.01
56.00	05600	RADIOISOTOPE	51,891	0	51,891		56.00
57.00	05700	CT SCAN	81,650	0	81,650		57.00
58.00	05800	MRI	66,233	0	66,233		58.00
60.00	06000	LABORATORY	319,993	0	319,993		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	27,340	0	27,340		62.00
65.00	06500	RESPIRATORY THERAPY	87,935	0	87,935		65.00
66.00	06600	PHYSICAL THERAPY	332,315	0	332,315		66.00
67.00	06700	OCCUPATIONAL THERAPY	13,102	0	13,102		67.00
68.00	06800	SPEECH PATHOLOGY	6,933	0	6,933		68.00
69.00	06900	ELECTROCARDIOLOGY	305,023	0	305,023		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,272	0	43,272		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	142,495	0	142,495		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	202,510	0	202,510		73.00
74.00	07400	RENAL DIALYSIS	19,726	0	19,726		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	111,096	0	111,096		76.01
76.03	03951	WOUND CARE	145,882	0	145,882		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	572,215	0	572,215		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,376,908	0	7,376,908		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,609	0	31,609		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	617,365	0	617,365		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	SENIOR CIRCLE	13,917	0	13,917		193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0		194.00
194.01	07953	MARKETING	7,026	0	7,026		194.01
194.02	07952	NON ALLOWABLE MEALS	25,256	0	25,256		194.02
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)	8,072,081	0	8,072,081		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	235,363					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		235,363				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,208	1,208	22,703,238			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,845	23,845	3,495,884	-15,767,906	54,397,186	5.00
7.00	00700	OPERATION OF PLANT	51,154	51,154	343,467	0	4,081,221	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496	496	40,398	0	347,057	8.00
9.00	00900	HOUSEKEEPING	1,345	1,345	820,680	0	1,326,643	9.00
10.00	01000	DIETARY	3,665	3,665	425,316	0	1,168,924	10.00
11.00	01100	CAFETERIA	4,142	4,142	242,596	0	326,409	11.00
13.00	01300	NURSING ADMINISTRATION	5,710	5,710	672,714	0	1,132,692	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	2,331	142,668	0	511,628	14.00
15.00	01500	PHARMACY	2,120	2,120	966,260	0	1,351,061	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,430	3,430	393,624	0	1,400,739	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,992	36,992	3,425,128	0	6,262,059	30.00
31.00	03100	INTENSIVE CARE UNIT	12,244	12,244	1,374,298	0	2,331,542	31.00
43.00	04300	NURSERY	1,986	1,986	335,714	0	593,552	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,529	20,529	1,730,356	0	4,746,056	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,790	4,790	944,541	0	1,534,289	52.00
53.00	05300	ANESTHESIOLOGY	595	595	0	0	180,384	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,290	7,290	1,660,125	0	3,189,590	54.00
54.01	05401	ULTRASOUND	2,086	2,086	161,081	0	281,417	54.01
56.00	05600	RADIOISOTOPE	691	691	147,112	0	529,578	56.00
57.00	05700	CT SCAN	1,202	1,202	215,919	0	364,200	57.00
58.00	05800	MRI	1,277	1,277	69,843	0	139,202	58.00
60.00	06000	LABORATORY	4,738	4,738	909,055	0	2,707,864	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	252	52,956	0	814,310	62.00
65.00	06500	RESPIRATORY THERAPY	1,085	1,085	493,145	0	746,193	65.00
66.00	06600	PHYSICAL THERAPY	6,545	6,545	579,532	0	1,012,786	66.00
67.00	06700	OCCUPATIONAL THERAPY	165	165	127,224	0	170,347	67.00
68.00	06800	SPEECH PATHOLOGY	93	93	69,297	0	92,085	68.00
69.00	06900	ELECTROCARDIOLOGY	4,190	4,190	1,045,055	0	2,451,933	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,481,498	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,928,315	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,590,728	73.00
74.00	07400	RENAL DIALYSIS	334	334	0	0	244,894	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,356	2,356	0	0	89,335	76.01
76.03	03951	WOUND CARE	2,814	2,814	191,003	0	427,106	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,538	9,538	1,497,314	0	2,884,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	221,238	221,238	22,572,305	-15,767,906	53,439,845	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	676	676	0	0	23,184	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,200	13,200	0	0	452,714	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	249	249	53,797	0	84,956	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	77,136	0	396,487	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
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)	3,847,437	4,224,644	4,638,594		15,767,906	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.346822	17.949482	0.204314		0.289866	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			41,430		824,171	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001825		0.015151	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	159,156					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496	1,015				8.00
9.00	00900	HOUSEKEEPING	1,345	0	157,315			9.00
10.00	01000	DIETARY	3,665	0	3,665	157,890		10.00
11.00	01100	CAFETERIA	4,142	0	4,142	93,398	30,369	11.00
13.00	01300	NURSING ADMINISTRATION	5,710	0	5,710	0	695	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	0	2,331	0	572	14.00
15.00	01500	PHARMACY	2,120	0	2,120	0	1,102	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,430	0	3,430	0	1,238	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,992	300	36,992	36,651	6,428	30.00
31.00	03100	INTENSIVE CARE UNIT	12,244	68	12,244	5,620	1,949	31.00
43.00	04300	NURSERY	1,986	0	1,986	0	547	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,529	171	20,529	0	3,246	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,790	147	4,790	0	1,614	52.00
53.00	05300	ANESTHESIOLOGY	595	13	595	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,290	48	7,290	0	2,659	54.00
54.01	05401	ULTRASOUND	2,086	0	2,086	0	249	54.01
56.00	05600	RADIOISOTOPE	691	0	691	0	198	56.00
57.00	05700	CT SCAN	1,202	0	1,202	0	412	57.00
58.00	05800	MRI	1,277	0	1,277	0	115	58.00
60.00	06000	LABORATORY	4,738	0	4,738	0	2,427	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	0	252	0	108	62.00
65.00	06500	RESPIRATORY THERAPY	1,085	0	1,085	0	981	65.00
66.00	06600	PHYSICAL THERAPY	6,545	17	6,545	0	944	66.00
67.00	06700	OCCUPATIONAL THERAPY	165	0	165	0	200	67.00
68.00	06800	SPEECH PATHOLOGY	93	0	93	0	82	68.00
69.00	06900	ELECTROCARDIOLOGY	4,190	59	4,190	0	1,823	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	334	0	334	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,356	6	2,356	0	0	76.01
76.03	03951	WOUND CARE	2,814	2	2,814	0	361	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,538	183	9,538	913	2,233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	145,031	1,014	143,190	136,582	30,183	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	676	0	676	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,200	1	13,200	92	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	249	0	249	0	100	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	86	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	21,216	0	194.02
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)	5,264,228	464,063	1,755,679	1,669,880	1,592,049	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.075900	457.204926	11.160277	10.576224	52.423491	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,816,860	28,005	83,080	187,956	308,097	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	11.415592	27.591133	0.528112	1.190424	10.145115	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	13,290,635					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,702,762				14.00
15.00	01500	PHARMACY	0	29,084	3,595,850			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,403	0	556,003,673		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,425,128	615,651	0	40,293,332		30.00
31.00	03100	INTENSIVE CARE UNIT	1,374,298	123,868	0	8,227,804		31.00
43.00	04300	NURSERY	335,714	45,595	0	2,610,466		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,730,357	1,383,439	0	87,303,089		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	944,541	12,110	0	4,419,750		52.00
53.00	05300	ANESTHESIOLOGY	0	125,097	0	14,788,027		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,660,125	192,741	0	14,458,006		54.00
54.01	05401	ULTRASOUND	161,081	2,663	0	4,682,721		54.01
56.00	05600	RADIOISOTOPE	147,112	2,630	0	18,402,951		56.00
57.00	05700	CT SCAN	215,919	45,418	0	30,913,525		57.00
58.00	05800	MRI	69,843	5,637	0	6,314,396		58.00
60.00	06000	LABORATORY	0	602,574	0	76,877,928		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	38,071	0	4,953,290		62.00
65.00	06500	RESPIRATORY THERAPY	493,145	63,071	0	11,921,667		65.00
66.00	06600	PHYSICAL THERAPY	0	24,989	0	8,454,178		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,810,912		67.00
68.00	06800	SPEECH PATHOLOGY	0	142	0	798,003		68.00
69.00	06900	ELECTROCARDIOLOGY	1,045,055	444,016	0	69,806,632		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,435,325	0	12,983,680		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,928,315	0	34,006,355		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,595,850	46,938,532		73.00
74.00	07400	RENAL DIALYSIS	0	116	0	1,639,761		74.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	8,488	0	1,547,800		76.01
76.03	03951	WOUND CARE	191,003	51,321	0	1,386,550		76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,497,314	509,018	0	50,464,318		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,290,635	10,701,782	3,595,850	556,003,673		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	SENIOR CIRCLE	0	469	0	0		193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0		194.00
194.01	07953	MARKETING	0	508	0	0		194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0		194.02
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)	1,750,043	793,033	1,896,395	2,024,315		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.131675	0.074096	0.527384	0.003641		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	289,471	121,600	131,772	193,245		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.021780	0.011362	0.036646	0.000348		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,218,709		11,218,709	0	11,218,709	30.00
31.00	03100	INTENSIVE CARE UNIT	3,961,801		3,961,801	0	3,961,801	31.00
43.00	04300	NURSERY	939,220		939,220	0	939,220	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,926,375		7,926,375	0	7,926,375	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,484,101		2,484,101	0	2,484,101	52.00
53.00	05300	ANESTHESIOLOGY	328,047		328,047	0	328,047	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,883,485		4,883,485	0	4,883,485	54.00
54.01	05401	ULTRASOUND	506,776		506,776	0	506,776	54.01
56.00	05600	RADIOISOTOPE	810,603		810,603	0	810,603	56.00
57.00	05700	CT SCAN	688,891		688,891	0	688,891	57.00
58.00	05800	MRI	274,677		274,677	0	274,677	58.00
60.00	06000	LABORATORY	4,154,166		4,154,166	0	4,154,166	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,088,016		1,088,016	0	1,088,016	62.00
65.00	06500	RESPIRATORY THERAPY	1,174,927	0	1,174,927	0	1,174,927	65.00
66.00	06600	PHYSICAL THERAPY	1,685,778	0	1,685,778	0	1,685,778	66.00
67.00	06700	OCCUPATIONAL THERAPY	244,103	0	244,103	0	244,103	67.00
68.00	06800	SPEECH PATHOLOGY	130,107	0	130,107	0	130,107	68.00
69.00	06900	ELECTROCARDIOLOGY	3,895,232		3,895,232	0	3,895,232	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,064,560		2,064,560	0	2,064,560	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,845,853		6,845,853	0	6,845,853	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,698,856		6,698,856	0	6,698,856	73.00
74.00	07400	RENAL DIALYSIS	336,634		336,634	0	336,634	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	228,459		228,459	0	228,459	76.01
76.03	03951	WOUND CARE	729,231		729,231	0	729,231	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,771,170		4,771,170	0	4,771,170	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,579,939		1,579,939		1,579,939	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
200.00		Subtotal (see instructions)	69,649,716	0	69,649,716	0	69,649,716	200.00
201.00		Less Observation Beds	1,579,939		1,579,939		1,579,939	201.00
202.00		Total (see instructions)	68,069,777	0	68,069,777	0	68,069,777	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,741,978		34,741,978			30.00
31.00	03100	INTENSIVE CARE UNIT	8,227,804		8,227,804			31.00
43.00	04300	NURSERY	2,610,466		2,610,466			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,274,261	52,028,828	87,303,089	0.090791	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,371,469	48,281	4,419,750	0.562046	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	7,396,943	7,391,084	14,788,027	0.022183	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,243,184	11,214,822	14,458,006	0.337770	0.000000	54.00
54.01	05401	ULTRASOUND	1,464,270	3,218,451	4,682,721	0.108223	0.000000	54.01
56.00	05600	RADIOISOTOPE	6,502,362	11,900,589	18,402,951	0.044047	0.000000	56.00
57.00	05700	CT SCAN	8,904,203	22,009,322	30,913,525	0.022284	0.000000	57.00
58.00	05800	MRI	1,152,584	5,161,812	6,314,396	0.043500	0.000000	58.00
60.00	06000	LABORATORY	33,637,648	43,240,280	76,877,928	0.054036	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,804,384	2,148,906	4,953,290	0.219655	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	9,801,198	2,120,469	11,921,667	0.098554	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,304,853	4,149,325	8,454,178	0.199402	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,386,942	423,970	1,810,912	0.134796	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	671,126	126,877	798,003	0.163041	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	41,549,168	28,257,464	69,806,632	0.055800	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,527,257	3,456,423	12,983,680	0.159012	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,940,407	10,065,948	34,006,355	0.201311	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,474,814	24,463,718	46,938,532	0.142715	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,593,871	45,890	1,639,761	0.205295	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	46,100	1,501,700	1,547,800	0.147602	0.000000	76.01
76.03	03951	WOUND CARE	115,926	1,270,624	1,386,550	0.525932	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	11,899,953	38,564,365	50,464,318	0.094545	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,458,270	4,093,084	5,551,354	0.284604	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
200.00		Subtotal (see instructions)	279,101,441	276,902,232	556,003,673			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	279,101,441	276,902,232	556,003,673			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.090791	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.562046	52.00
53.00	05300	ANESTHESIOLOGY	0.022183	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337770	54.00
54.01	05401	ULTRASOUND	0.108223	54.01
56.00	05600	RADIOISOTOPE	0.044047	56.00
57.00	05700	CT SCAN	0.022284	57.00
58.00	05800	MRI	0.043500	58.00
60.00	06000	LABORATORY	0.054036	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.219655	62.00
65.00	06500	RESPIRATORY THERAPY	0.098554	65.00
66.00	06600	PHYSICAL THERAPY	0.199402	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.134796	67.00
68.00	06800	SPEECH PATHOLOGY	0.163041	68.00
69.00	06900	ELECTROCARDIOLOGY	0.055800	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.159012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.201311	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142715	73.00
74.00	07400	RENAL DIALYSIS	0.205295	74.00
76.00	03020	ACUPUNCTURE	0.000000	76.00
76.01	03610	SLEEP LAB	0.147602	76.01
76.03	03951	WOUND CARE	0.525932	76.03
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.094545	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284604	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
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: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/25/2015 7:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,218,709		11,218,709	0	11,218,709	30.00
31.00	03100	INTENSIVE CARE UNIT	3,961,801		3,961,801	0	3,961,801	31.00
43.00	04300	NURSERY	939,220		939,220	0	939,220	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,926,375		7,926,375	0	7,926,375	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,484,101		2,484,101	0	2,484,101	52.00
53.00	05300	ANESTHESIOLOGY	328,047		328,047	0	328,047	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,883,485		4,883,485	0	4,883,485	54.00
54.01	05401	ULTRASOUND	506,776		506,776	0	506,776	54.01
56.00	05600	RADIOISOTOPE	810,603		810,603	0	810,603	56.00
57.00	05700	CT SCAN	688,891		688,891	0	688,891	57.00
58.00	05800	MRI	274,677		274,677	0	274,677	58.00
60.00	06000	LABORATORY	4,154,166		4,154,166	0	4,154,166	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,088,016		1,088,016	0	1,088,016	62.00
65.00	06500	RESPIRATORY THERAPY	1,174,927	0	1,174,927	0	1,174,927	65.00
66.00	06600	PHYSICAL THERAPY	1,685,778	0	1,685,778	0	1,685,778	66.00
67.00	06700	OCCUPATIONAL THERAPY	244,103	0	244,103	0	244,103	67.00
68.00	06800	SPEECH PATHOLOGY	130,107	0	130,107	0	130,107	68.00
69.00	06900	ELECTROCARDIOLOGY	3,895,232		3,895,232	0	3,895,232	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,064,560		2,064,560	0	2,064,560	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,845,853		6,845,853	0	6,845,853	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,698,856		6,698,856	0	6,698,856	73.00
74.00	07400	RENAL DIALYSIS	336,634		336,634	0	336,634	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	228,459		228,459	0	228,459	76.01
76.03	03951	WOUND CARE	729,231		729,231	0	729,231	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,771,170		4,771,170	0	4,771,170	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,579,939		1,579,939		1,579,939	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
200.00		Subtotal (see instructions)	69,649,716	0	69,649,716	0	69,649,716	200.00
201.00		Less Observation Beds	1,579,939		1,579,939		1,579,939	201.00
202.00		Total (see instructions)	68,069,777	0	68,069,777	0	68,069,777	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/25/2015 7:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,741,978		34,741,978			30.00
31.00	03100	INTENSIVE CARE UNIT	8,227,804		8,227,804			31.00
43.00	04300	NURSERY	2,610,466		2,610,466			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,274,261	52,028,828	87,303,089	0.090791	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,371,469	48,281	4,419,750	0.562046	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	7,396,943	7,391,084	14,788,027	0.022183	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,243,184	11,214,822	14,458,006	0.337770	0.000000	54.00
54.01	05401	ULTRASOUND	1,464,270	3,218,451	4,682,721	0.108223	0.000000	54.01
56.00	05600	RADIOISOTOPE	6,502,362	11,900,589	18,402,951	0.044047	0.000000	56.00
57.00	05700	CT SCAN	8,904,203	22,009,322	30,913,525	0.022284	0.000000	57.00
58.00	05800	MRI	1,152,584	5,161,812	6,314,396	0.043500	0.000000	58.00
60.00	06000	LABORATORY	33,637,648	43,240,280	76,877,928	0.054036	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,804,384	2,148,906	4,953,290	0.219655	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	9,801,198	2,120,469	11,921,667	0.098554	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,304,853	4,149,325	8,454,178	0.199402	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,386,942	423,970	1,810,912	0.134796	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	671,126	126,877	798,003	0.163041	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	41,549,168	28,257,464	69,806,632	0.055800	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,527,257	3,456,423	12,983,680	0.159012	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,940,407	10,065,948	34,006,355	0.201311	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,474,814	24,463,718	46,938,532	0.142715	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,593,871	45,890	1,639,761	0.205295	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	46,100	1,501,700	1,547,800	0.147602	0.000000	76.01
76.03	03951	WOUND CARE	115,926	1,270,624	1,386,550	0.525932	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	11,899,953	38,564,365	50,464,318	0.094545	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,458,270	4,093,084	5,551,354	0.284604	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
200.00		Subtotal (see instructions)	279,101,441	276,902,232	556,003,673			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	279,101,441	276,902,232	556,003,673			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/25/2015 7:15 am

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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.03	03951	WOUND CARE	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
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: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part I Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,024,375	0	2,024,375	14,315	141.42	30.00
31.00	INTENSIVE CARE UNIT	666,536		666,536	1,886	353.41	31.00
43.00	NURSERY	115,726		115,726	1,645	70.35	43.00
200.00	Total (lines 30-199)	2,806,637		2,806,637	17,846		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,444	769,890				30.00
31.00	INTENSIVE CARE UNIT	1,048	370,374				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	6,492	1,140,264				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part II Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,145,518	87,303,089	0.013121	13,908,936	182,499	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	289,138	4,419,750	0.065420	16,920	1,107	52.00
53.00	05300	ANESTHESIOLOGY	37,171	14,788,027	0.002514	2,713,053	6,821	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	460,124	14,458,006	0.031825	1,783,485	56,759	54.00
54.01	05401	ULTRASOUND	108,709	4,682,721	0.023215	759,397	17,629	54.01
56.00	05600	RADIOISOTOPE	51,891	18,402,951	0.002820	3,321,590	9,367	56.00
57.00	05700	CT SCAN	81,650	30,913,525	0.002641	4,485,425	11,846	57.00
58.00	05800	MRI	66,233	6,314,396	0.010489	536,724	5,630	58.00
60.00	06000	LABORATORY	319,993	76,877,928	0.004162	16,735,604	69,654	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	27,340	4,953,290	0.005520	1,543,624	8,521	62.00
65.00	06500	RESPIRATORY THERAPY	87,935	11,921,667	0.007376	5,309,630	39,164	65.00
66.00	06600	PHYSICAL THERAPY	332,315	8,454,178	0.039308	2,609,548	102,576	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,102	1,810,912	0.007235	817,284	5,913	67.00
68.00	06800	SPEECH PATHOLOGY	6,933	798,003	0.008688	58,560	509	68.00
69.00	06900	ELECTROCARDIOLOGY	305,023	69,806,632	0.004370	20,995,470	91,750	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,272	12,983,680	0.003333	4,788,832	15,961	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	142,495	34,006,355	0.004190	11,488,321	48,136	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	202,510	46,938,532	0.004314	10,045,448	43,336	73.00
74.00	07400	RENAL DIALYSIS	19,726	1,639,761	0.012030	954,503	11,483	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	111,096	1,547,800	0.071777	8,000	574	76.01
76.03	03951	WOUND CARE	145,882	1,386,550	0.105212	7,023	739	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	572,215	50,464,318	0.011339	5,898,810	66,887	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	285,094	5,551,354	0.051356	687,607	35,313	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50-199)	4,855,365	510,423,425		109,473,794	832,174	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part III Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,315	0.00	5,444	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,886	0.00	1,048	0		31.00
43.00	04300	NURSERY	1,645	0.00	0	0		43.00
200.00		Total (lines 30-199)	17,846		6,492	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV | Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	87,303,089	0.000000	0.000000	13,908,936	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,419,750	0.000000	0.000000	16,920	52.00
53.00	05300	ANESTHESIOLOGY	0	14,788,027	0.000000	0.000000	2,713,053	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,458,006	0.000000	0.000000	1,783,485	54.00
54.01	05401	ULTRASOUND	0	4,682,721	0.000000	0.000000	759,397	54.01
56.00	05600	RADIOISOTOPE	0	18,402,951	0.000000	0.000000	3,321,590	56.00
57.00	05700	CT SCAN	0	30,913,525	0.000000	0.000000	4,485,425	57.00
58.00	05800	MRI	0	6,314,396	0.000000	0.000000	536,724	58.00
60.00	06000	LABORATORY	0	76,877,928	0.000000	0.000000	16,735,604	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,953,290	0.000000	0.000000	1,543,624	62.00
65.00	06500	RESPIRATORY THERAPY	0	11,921,667	0.000000	0.000000	5,309,630	65.00
66.00	06600	PHYSICAL THERAPY	0	8,454,178	0.000000	0.000000	2,609,548	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,810,912	0.000000	0.000000	817,284	67.00
68.00	06800	SPEECH PATHOLOGY	0	798,003	0.000000	0.000000	58,560	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69,806,632	0.000000	0.000000	20,995,470	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	12,983,680	0.000000	0.000000	4,788,832	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	34,006,355	0.000000	0.000000	11,488,321	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	46,938,532	0.000000	0.000000	10,045,448	73.00
74.00	07400	RENAL DIALYSIS	0	1,639,761	0.000000	0.000000	954,503	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	1,547,800	0.000000	0.000000	8,000	76.01
76.03	03951	WOUND CARE	0	1,386,550	0.000000	0.000000	7,023	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	50,464,318	0.000000	0.000000	5,898,810	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,551,354	0.000000	0.000000	687,607	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	510,423,425			109,473,794	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	11,796,954	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	1,393,458	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,302,435	0		54.00
54.01	05401	ULTRASOUND	0	1,086,144	0		54.01
56.00	05600	RADIOISOTOPE	0	3,319,380	0		56.00
57.00	05700	CT SCAN	0	5,980,612	0		57.00
58.00	05800	MRI	0	1,557,499	0		58.00
60.00	06000	LABORATORY	0	6,740,319	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,209,480	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	860,112	0		65.00
66.00	06600	PHYSICAL THERAPY	0	1,424	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	534	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,820,719	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	902,573	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,685,066	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,060,571	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	0	529,250	0		76.01
76.03	03951	WOUND CARE	0	525,968	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	7,010,447	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,265,364	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00		Total (lines 50-199)	0	73,048,309	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part V Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.090791	11,796,954	0	0	1,071,057	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.562046	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.022183	1,393,458	0	0	30,911	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337770	3,302,435	0	0	1,115,463	54.00
54.01	05401	ULTRASOUND	0.108223	1,086,144	0	0	117,546	54.01
56.00	05600	RADIOISOTOPE	0.044047	3,319,380	0	0	146,209	56.00
57.00	05700	CT SCAN	0.022284	5,980,612	0	0	133,272	57.00
58.00	05800	MRI	0.043500	1,557,499	0	0	67,751	58.00
60.00	06000	LABORATORY	0.054036	6,740,319	0	0	364,220	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.219655	1,209,480	0	0	265,668	62.00
65.00	06500	RESPIRATORY THERAPY	0.098554	860,112	0	0	84,767	65.00
66.00	06600	PHYSICAL THERAPY	0.199402	1,424	0	0	284	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.134796	534	0	0	72	67.00
68.00	06800	SPEECH PATHOLOGY	0.163041	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.055800	11,820,719	0	0	659,596	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.159012	902,573	0	0	143,520	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.201311	3,685,066	0	0	741,844	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142715	10,060,571	0	33,956	1,435,794	73.00
74.00	07400	RENAL DIALYSIS	0.205295	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.147602	529,250	0	0	78,118	76.01
76.03	03951	WOUND CARE	0.525932	525,968	0	0	276,623	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.094545	7,010,447	0	0	662,803	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284604	1,265,364	0	0	360,128	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		73,048,309	0	33,956	7,755,646	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		73,048,309	0	33,956	7,755,646	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part V Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,846		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	4,846		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	4,846		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,315	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,315	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)	12,299	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,444	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)	11,218,709	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)	11,218,709	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)	11,218,709	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)	783.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,266,463	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	4,266,463	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/25/2015 7:15 am

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	3,961,801	1,886	2,100.64	1,048	2,201,471	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	11,327,056	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	17,794,990	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)	1,140,264	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	832,174	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,972,438	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	15,822,552	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)	2,016	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	783.70	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,579,939	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,024,375	11,218,709	0.180446	1,579,939	285,094	90.00
91.00	Nursing School cost	0	11,218,709	0.000000	1,579,939	0	91.00
92.00	Allied health cost	0	11,218,709	0.000000	1,579,939	0	92.00
93.00	All other Medical Education	0	11,218,709	0.000000	1,579,939	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-3 | Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		16,498,670		30.00
31.00	03100	INTENSIVE CARE UNIT		4,567,606		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.090791	13,908,936	1,262,806	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.562046	16,920	9,510	52.00
53.00	05300	ANESTHESIOLOGY	0.022183	2,713,053	60,184	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337770	1,783,485	602,408	54.00
54.01	05401	ULTRASOUND	0.108223	759,397	82,184	54.01
56.00	05600	RADIOISOTOPE	0.044047	3,321,590	146,306	56.00
57.00	05700	CT SCAN	0.022284	4,485,425	99,953	57.00
58.00	05800	MRI	0.043500	536,724	23,347	58.00
60.00	06000	LABORATORY	0.054036	16,735,604	904,325	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.219655	1,543,624	339,065	62.00
65.00	06500	RESPIRATORY THERAPY	0.098554	5,309,630	523,285	65.00
66.00	06600	PHYSICAL THERAPY	0.199402	2,609,548	520,349	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.134796	817,284	110,167	67.00
68.00	06800	SPEECH PATHOLOGY	0.163041	58,560	9,548	68.00
69.00	06900	ELECTROCARDIOLOGY	0.055800	20,995,470	1,171,547	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.159012	4,788,832	761,482	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.201311	11,488,321	2,312,725	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142715	10,045,448	1,433,636	73.00
74.00	07400	RENAL DIALYSIS	0.205295	954,503	195,955	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.147602	8,000	1,181	76.01
76.03	03951	WOUND CARE	0.525932	7,023	3,694	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.094545	5,898,810	557,703	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284604	687,607	195,696	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		109,473,794	11,327,056	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)		109,473,794		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part A Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

			MDH	Non MDH	On or After Geo Reclassification		
		0	1.00	1.01	1.02	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS						
1.00	DRG Amounts Other than Outlier Payments		0	0	0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		5,049,077	0	0		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		0	6,909,354	0		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	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	0		1.04
2.00	Outlier payments for discharges. (see instructions)		253,326	0	0		2.00
2.01	Outlier reconciliation amount		0	0	0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	0	0		2.02
3.00	Managed Care Simulated Payments		1,050,077	0	0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		92.48				4.00
	Indirect Medical Education Adjustment						
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00				5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00				6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00				7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00				7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00				8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00				8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00				9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00				10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00				11.00
12.00	Current year allowable FTE (see instructions)		0.00				12.00
13.00	Total allowable FTE count for the prior year.		0.00				13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00				14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00				15.00
16.00	Adjustment for residents in initial years of the program		0.00				16.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part A Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

			MDH	Non MDH	On or After Geo Reclassification		
		0	1.00	1.01	1.02	2.00	
17.00	Adjusment for residents displaced by program or hospital closure		0.00				17.00
18.00	Adjusted rolling average FTE count		0.00				18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000				19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000				20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000				21.00
22.00	IME payment adjustment (see instructions)		0	0	0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	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).		0.00				23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00				24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00				25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000				26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000				27.00
28.00	IME add-on adjustment amount (see instructions)		0	0	0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	0	0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	0	0		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	0	0		29.01
	Disproportionate Share Adjustment						
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		6.03				30.00
31.00	Percentage of Medicaid patient days (see instructions)		32.41				31.00
32.00	Sum of lines 30 and 31		38.44				32.00
33.00	Allowable disproportionate share percentage (see instructions)		20.93	12.00	0.00		33.00
34.00	Disproportionate share adjustment (see instructions)		264,193	207,281	0		34.00

			Prior to October 1			
		0	1.00	1.01	1.02	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		9,046,380,143			35.00
35.01	Factor 3 (see instructions)		0.000151634			35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,371,742			35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		575,004			35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,269,147			36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	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 an 685. (see instructions)		0			43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part A Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

			Prior to October 1			
		0	1.00	1.01	1.02	
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	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)		6,141,600	7,810,778	0	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		5,823,779	0	0	48.00
49.00	Total payment for inpatient operating costs (see instructions)		13,952,378			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		992,806			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		14,945,184			59.00
60.00	Primary payer payments		0			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		14,945,184			61.00
62.00	Deductibles billed to program beneficiaries		1,487,332			62.00
63.00	Coinsurance billed to program beneficiaries		29,642			63.00
64.00	Allowable bad debts (see instructions)		182,285			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		118,485			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		128,436			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		13,546,695			67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0			68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0			69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0			70.00
70.50	RURAL DEMONSTRATION PROJECT		0			70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0			70.91
70.92	Bundled Model 1 discount amount (see instructions)		0			70.92
70.93	HVBP payment adjustment amount (see instructions)		-9,181			70.93
70.94	HRR adjustment amount (see instructions)		-112,170			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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part A Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

			Prior to October 1			
		0	1.00	1.01	1.02	
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)		13,425,344			71.00
71.01	Sequestration adjustment (see instructions)		268,507			71.01
72.00	Interim payments		13,525,854			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)		-369,017			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		857,794			75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0			90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00			94.00
95.00	Time value of money for operating expenses (see instructions)		0			95.00
96.00	Time value of money for capital related expenses (see instructions)		0			96.00

		Prior to 10/1			On/After 10/1	
		1.00	1.01	1.02	2.00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)	0			0	100.00
	HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	1.00008			0.998612	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0			0	102.00
	HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.9927			0.9891	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0			0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part A Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		On/After October 1		
		2.00		
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	7,647,644,885		35.00
35.01	Factor 3 (see instructions)	0.000156271		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,195,105		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	694,143		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)			36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)			41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)			41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)			45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)			46.00
47.00	Subtotal (see instructions)			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)			48.00
49.00	Total payment for inpatient operating costs (see instructions)			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			52.00
53.00	Nursing and Allied Health Managed Care payment			53.00
54.00	Special add-on payments for new technologies			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			58.00
59.00	Total (sum of amounts on lines 49 through 58)			59.00
60.00	Primary payer payments			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			61.00
62.00	Deductibles billed to program beneficiaries			62.00
63.00	Coinsurance billed to program beneficiaries			63.00
64.00	Allowable bad debts (see instructions)			64.00
65.00	Adjusted reimbursable bad debts (see instructions)			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			68.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part A Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		On/After October 1	
		2.00	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		70.00
70.50	RURAL DEMONSTRATION PROJECT		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		70.91
70.92	Bundled Model 1 discount amount (see instructions)		70.92
70.93	HVBP payment adjustment amount (see instructions)		70.93
70.94	HRR adjustment amount (see instructions)		70.94
70.95	Recovery of accelerated depreciation		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)		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)		70.97
70.98	Low Volume Payment-3		70.98
70.99	HAC adjustment amount (see instructions)		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		71.00
71.01	Sequestration adjustment (see instructions)		71.01
72.00	Interim payments		72.00
73.00	Tentative settlement (for contractor use only)		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		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)		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		93.00
94.00	The rate used to calculate the time value of money (see instructions)		94.00
95.00	Time value of money for operating expenses (see instructions)		95.00
96.00	Time value of money for capital related expenses (see instructions)		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140184	Period: From 05/01/2014 To 04/30/2015	Worksheet E Part B Date/Time Prepared: 9/25/2015 7:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,846	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,755,646	2.00
3.00	PPS payments	6,247,459	3.00
4.00	Outlier payment (see instructions)	122,417	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,846	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	33,956	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)	33,956	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	33,956	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	29,110	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)	4,846	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)	6,369,876	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,332,628	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)	5,042,094	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	5,042,094	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	5,042,094	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)	180,823	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	117,535	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	146,254	36.00
37.00	Subtotal (see instructions)	5,159,629	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)	5,159,629	40.00
40.01	Sequestration adjustment (see instructions)	103,193	40.01
41.00	Interim payments	5,121,198	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-64,762	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E-1 Part I Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		13,525,854		5,121,198	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		13,525,854		5,121,198	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		369,017		64,762	6.02
7.00	Total Medicare program liability (see instructions)		13,156,837		5,056,436	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140184 | Component CCN: 14U184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140184	Period: From 05/01/2014 To 04/30/2015	Worksheet E-1 Part II Date/Time Prepared: 9/25/2015 7:15 am
	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	4,803	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	6,492	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	604	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	14,185	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	556,003,673	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	394,079	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1,025,279	8.00
9.00	Sequestration adjustment amount (see instructions)	20,506	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,004,773	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1,166,657	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)	-161,884	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 140184 Component CCN: 14U184	Period: From 05/01/2014 To 04/30/2015	Worksheet E-2 Date/Time Prepared: 9/25/2015 7:15 am
	Title XVIII	Swing Beds - SNF	PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
20.00	Interim payments	0	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet G | Date/Time Prepared: 9/25/2015 7:15 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-1,192,796	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	19,405,304	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,890,913	0	0	0	6.00
7.00	Inventory	2,947,846	0	0	0	7.00
8.00	Prepaid expenses	1,158,747	0	0	0	8.00
9.00	Other current assets	-76,597	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)	19,351,591	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,393,860	0	0	0	12.00
13.00	Land improvements	562,648	0	0	0	13.00
14.00	Accumulated depreciation	-360,876	0	0	0	14.00
15.00	Buildings	46,974,794	0	0	0	15.00
16.00	Accumulated depreciation	-10,930,708	0	0	0	16.00
17.00	Leasehold improvements	3,828,658	0	0	0	17.00
18.00	Accumulated depreciation	-1,794,940	0	0	0	18.00
19.00	Fixed equipment	2,278,523	0	0	0	19.00
20.00	Accumulated depreciation	-1,438,030	0	0	0	20.00
21.00	Automobiles and trucks	2,994	0	0	0	21.00
22.00	Accumulated depreciation	-2,994	0	0	0	22.00
23.00	Major movable equipment	18,628,685	0	0	0	23.00
24.00	Accumulated depreciation	-11,315,135	0	0	0	24.00
25.00	Minor equipment depreciable	5,829,209	0	0	0	25.00
26.00	Accumulated depreciation	-4,024,899	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	49,631,789	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	4,915,313	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,915,313	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	73,898,693	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,058,649	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,771,167	0	0	0	38.00
39.00	Payroll taxes payable	-319	0	0	0	39.00
40.00	Notes and loans payable (short term)	15,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-282,160,328	0	0	0	43.00
44.00	Other current liabilities	1,643,335	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-274,672,496	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	33,750	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	33,750	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	-274,638,746	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	348,537,439				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	348,537,439	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	73,898,693	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet G-1 | Date/Time Prepared: 9/25/2015 7:15 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		304,071,926		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		44,465,514				2.00
3.00	Total (sum of line 1 and line 2)		348,537,440		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		348,537,440		0		11.00
12.00	ROUNDING	1		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		348,537,439		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	ROUNDING		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/25/2015 7:15 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	37,352,444		37,352,444	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)	37,352,444		37,352,444	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	8,227,804		8,227,804	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	8,227,804		8,227,804	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	45,580,248		45,580,248	17.00
18.00	Ancillary services	220,162,970	234,244,783	454,407,753	18.00
19.00	Outpatient services	13,358,223	42,657,449	56,015,672	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CRNA CHARGES	1,741,287	1,654,836	3,396,123	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	280,842,728	278,557,068	559,399,796	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		78,413,164		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)		78,413,164		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140184	Period: From 05/01/2014 To 04/30/2015	Worksheet G-3 Date/Time Prepared: 9/25/2015 7:15 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	559,399,796	1.00
2.00	Less contractual allowances and discounts on patients' accounts	438,127,936	2.00
3.00	Net patient revenues (line 1 minus line 2)	121,271,860	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	78,413,164	4.00
5.00	Net income from service to patients (line 3 minus line 4)	42,858,696	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,606,818	24.00
25.00	Total other income (sum of lines 6-24)	1,606,818	25.00
26.00	Total (line 5 plus line 25)	44,465,514	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	44,465,514	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140184	Period: From 05/01/2014 To 04/30/2015	Worksheet L Parts I-III Date/Time Prepared: 9/25/2015 7:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	941,994	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	50,812	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)	38.86	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	992,806	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

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: 140184	Period: From 05/01/2014 To 04/30/2015	Worksheet S Parts I-III Date/Time Prepared: 9/25/2015 7:22 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/25/2015 Time: 7:22 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARION MEMORIAL HOSPITAL (140184) for the cost reporting period beginning 05/01/2014 and ending 04/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-369,017	-64,762	-161,884	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
200.00	Total	0	-369,017	-64,762	-161,884	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 9/25/2015 7:15 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 917 WEST MAIN ST	PO Box:			1.00
2.00	City: MARION	State: IL	Zip Code: 62959	County: WILLIAMSON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	MARION MEMORIAL HOSPITAL	140184	16060	1	07/01/1996	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	MARION MEMORIAL HOSPITAL	14U184	16060		03/23/1999	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
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)	05/01/2014	04/30/2015	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3,963	877	0	7	28	256	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: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/25/2015 7:15 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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.	1		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.	05/01/2014	09/30/2014	38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/25/2015 7:15 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140184	Period: From 05/01/2014 To 04/30/2015	Worksheet S-2 Part I Date/Time Prepared: 9/25/2015 7:15 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/25/2015 7:15 am

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	69,997	5,012,203	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: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 9/25/2015 7:15 am

		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	449008	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: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD.	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	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.	Y	145.00

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.75	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140184	Period: From 05/01/2014 To 04/30/2015	Worksheet S-2 Part I Date/Time Prepared: 9/25/2015 7:15 am

		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)	04/01/2014	06/30/2014	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. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 9/25/2015 7:15 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y			3.00
			Y/N	Type	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N			5.00
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.			N		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	
					1.00	
	Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N	14.00
	Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				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	08/17/2015	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: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 9/25/2015 7:15 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				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.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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.				N	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.	Y	12/31/2014	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.	MICHAEL	TEA	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-628-6555	MICHAEL_TEA@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 9/25/2015 7:15 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	08/17/2015			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.		REVENUE MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 9/25/2015 7:15 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	80	29,200	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)		80	29,200	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	18	6,570	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		98	35,770	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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		98				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 9/25/2015 7:15 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,444	2,967	12,299			1.00
2.00	HMO and other (see instructions)	604	559				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,444	2,967	12,299			7.00
8.00	INTENSIVE CARE UNIT	1,048	182	1,886			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1,423	1,645			13.00
14.00	Total (see instructions)	6,492	4,572	15,830	0.00	430.01	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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	430.01	27.00
28.00	Observation Bed Days		0	2,016			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 9/25/2015 7:15 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,680	1,643	4,803	1.00
2.00	HMO and other (see instructions)			161	0		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	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,680	1,643	4,803	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						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: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 9/25/2015 7:15 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	22,909,167	0	22,909,167	894,417.00	25.61	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		110,574	20,359	130,933	3,864.00	33.89	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		503,514	0	503,514	15,546.00	32.39	11.00
12.00	Contract labor: Top level management and other management and administrative services		48,791	0	48,791	522.00	93.47	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		1,816,485	0	1,816,485	34,026.00	53.39	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)		6,171,805	0	6,171,805			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		30,348	0	30,348			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	205,929	0	205,929	6,753.00	30.49	26.00
27.00	Administrative & General	5.00	2,720,812	775,072	3,495,884	119,887.00	29.16	27.00
28.00	Administrative & General under contract (see inst.)		303,874	0	303,874	2,886.25	105.28	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	343,467	0	343,467	13,886.00	24.73	30.00
31.00	Laundry & Linen Service	8.00	40,398	0	40,398	3,061.00	13.20	31.00
32.00	Housekeeping	9.00	820,680	0	820,680	67,193.00	12.21	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	667,912	-242,596	425,316	33,089.85	12.85	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	242,596	242,596	18,874.15	12.85	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,524,922	-852,208	672,714	14,455.00	46.54	38.00
39.00	Central Services and Supply	14.00	142,668	0	142,668	11,895.00	11.99	39.00
40.00	Pharmacy	15.00	966,260	0	966,260	22,924.00	42.15	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 9/25/2015 7:15 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	393,624	0	393,624	25,743.00	15.29	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: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 9/25/2015 7:15 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		23,213,041	0	23,213,041	897,303.25	25.87	1.00
2.00	Excluded area salaries (see instructions)		110,574	20,359	130,933	3,864.00	33.89	2.00
3.00	Subtotal salaries (line 1 minus line 2)		23,102,467	-20,359	23,082,108	893,439.25	25.84	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,368,790	0	2,368,790	50,094.00	47.29	4.00
5.00	Subtotal wage-related costs (see inst.)		6,171,805	0	6,171,805	0.00	26.74	5.00
6.00	Total (sum of lines 3 thru 5)		31,643,062	-20,359	31,622,703	943,533.25	33.52	6.00
7.00	Total overhead cost (see instructions)		8,130,546	-77,136	8,053,410	340,647.25	23.64	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part IV Date/Time Prepared: 9/25/2015 7:15 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	325,892	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,148,906	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	33,367	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	18,749	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-66	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	9,546	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	633,606	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,340,384	17.00
18.00	Medicare Taxes - Employers Portion Only	313,477	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	215,146	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	163,145	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,202,152	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part V Date/Time Prepared: 9/25/2015 7:15 am

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-10 | Date/Time Prepared: 9/25/2015 7:15 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.122427	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	9,416,913	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	6,650,534	5.00
6.00	Medicaid charges	148,511,753	6.00
7.00	Medicaid cost (line 1 times line 6)	18,181,848	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)	2,114,401	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	3,343	9.00
10.00	Stand-alone SCHIP charges	40,361	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	4,941	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	1,598	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,115,999	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	333,621	60,458	394,079	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	40,844	7,402	48,246	21.00
22.00	Partial payment by patients approved for charity care	350	0	350	22.00
23.00	Cost of charity care (line 21 minus line 22)	40,494	7,402	47,896	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	5,016,037	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	236,020	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,780,017	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	585,203	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	633,099	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,749,098	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,152,499	1,152,499	2,097,641	3,250,140	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,122,735	4,122,735	1,054,016	5,176,751	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	205,929	148,219	354,148	4,245,752	4,599,900	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,720,812	16,250,431	18,971,243	-5,837,832	13,133,411	5.00
7.00	00700	OPERATION OF PLANT	343,467	1,925,772	2,269,239	0	2,269,239	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	40,398	281,394	321,792	0	321,792	8.00
9.00	00900	HOUSEKEEPING	820,680	292,159	1,112,839	0	1,112,839	9.00
10.00	01000	DIETARY	667,912	833,483	1,501,395	-545,065	956,330	10.00
11.00	01100	CAFETERIA	0	0	0	545,065	545,065	11.00
13.00	01300	NURSING ADMINISTRATION	1,524,922	252,596	1,777,518	-978,263	799,255	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	142,668	6,260,388	6,403,056	-6,000,521	402,535	14.00
15.00	01500	PHARMACY	966,260	3,816,821	4,783,081	-3,702,148	1,080,933	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	393,624	810,471	1,204,095	0	1,204,095	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,468,067	1,667,210	5,135,277	-240,624	4,894,653	30.00
31.00	03100	INTENSIVE CARE UNIT	1,374,298	257,335	1,631,633	-802	1,630,831	31.00
43.00	04300	NURSERY	232,813	64,487	297,300	159,548	456,848	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,409,251	3,253,796	4,663,047	-54,249	4,608,798	50.00
51.00	05100	RECOVERY ROOM	321,105	39,087	360,192	-360,192	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,004,503	101,030	1,105,533	71,494	1,177,027	52.00
53.00	05300	ANESTHESIOLOGY	0	4,385,605	4,385,605	-248	4,385,357	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,660,125	1,808,683	3,468,808	-190,901	3,277,907	54.00
54.01	05401	ULTRASOUND	161,081	74,284	235,365	-58,401	176,964	54.01
56.00	05600	RADIOISOTOPE	147,112	328,710	475,822	0	475,822	56.00
57.00	05700	CT SCAN	215,919	62,942	278,861	0	278,861	57.00
58.00	05800	MRI	69,843	11,293	81,136	0	81,136	58.00
60.00	06000	LABORATORY	962,011	2,247,930	3,209,941	-850,306	2,359,635	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	794,848	794,848	62.00
65.00	06500	RESPIRATORY THERAPY	493,145	174,338	667,483	-59,257	608,226	65.00
66.00	06600	PHYSICAL THERAPY	579,532	131,852	711,384	-41,474	669,910	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,224	11,470	138,694	0	138,694	67.00
68.00	06800	SPEECH PATHOLOGY	69,297	5,441	74,738	0	74,738	68.00
69.00	06900	ELECTROCARDIOLOGY	1,045,055	1,997,630	3,042,685	-414,596	2,628,089	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,481,568	1,481,568	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,928,315	4,928,315	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,595,850	3,595,850	73.00
74.00	07400	RENAL DIALYSIS	0	233,439	233,439	0	233,439	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	216,939	216,939	0	216,939	76.01
76.03	03951	WOUND CARE	191,003	120,513	311,516	-19,945	291,571	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,440,537	2,009,493	3,450,030	198,667	3,648,697	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	56,777	141,890	198,667	-198,667	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,855,370	55,492,365	78,347,735	-380,727	77,967,008	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3	3	0	3	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	53,797	11,629	65,426	0	65,426	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	380,727	380,727	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	22,909,167	55,503,997	78,413,164	0	78,413,164	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	597,297	3,847,437		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-952,107	4,224,644		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,736	4,597,164		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,102,437	14,235,848		5.00
7.00	00700	OPERATION OF PLANT	-12,591	2,256,648		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	321,792		8.00
9.00	00900	HOUSEKEEPING	0	1,112,839		9.00
10.00	01000	DIETARY	0	956,330		10.00
11.00	01100	CAFETERIA	-410,278	134,787		11.00
13.00	01300	NURSING ADMINISTRATION	160	799,415		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	402,535		14.00
15.00	01500	PHARMACY	0	1,080,933		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,416	1,202,679		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-601,085	4,293,568		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,630,831		31.00
43.00	04300	NURSERY	0	456,848		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-920,347	3,688,451		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,177,027		52.00
53.00	05300	ANESTHESIOLOGY	-4,225,379	159,978		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-677,524	2,600,383		54.00
54.01	05401	ULTRASOUND	0	176,964		54.01
56.00	05600	RADIOISOTOPE	0	475,822		56.00
57.00	05700	CT SCAN	0	278,861		57.00
58.00	05800	MRI	0	81,136		58.00
60.00	06000	LABORATORY	0	2,359,635		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	794,848		62.00
65.00	06500	RESPIRATORY THERAPY	0	608,226		65.00
66.00	06600	PHYSICAL THERAPY	0	669,910		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	138,694		67.00
68.00	06800	SPEECH PATHOLOGY	0	74,738		68.00
69.00	06900	ELECTROCARDIOLOGY	-533,376	2,094,713		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-70	1,481,498		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,928,315		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-5,122	3,590,728		73.00
74.00	07400	RENAL DIALYSIS	0	233,439		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	-208,406	8,533		76.01
76.03	03951	WOUND CARE	0	291,571		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,397,529	2,251,168		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,248,072	69,718,936		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	SENIOR CIRCLE	0	65,426		193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0		194.00
194.01	07953	MARKETING	0	380,727		194.01
194.02	07952	NON ALLOWABLE MEALS	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-8,248,072	70,165,092		200.00

RECLASSIFICATIONS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-6 | Date/Time Prepared: 9/25/2015 7:15 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,245,752		1.00
	TOTALS		0	4,245,752		
	B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	46,243		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	46,243		
	C - RENTAL AND LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,164,289		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,048,453		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
	TOTALS		0	2,212,742		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	90,410		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	842,942		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,563		3.00
	TOTALS		0	938,915		
	E - MARKETING DEPARTMENT					
1.00	MARKETING	194.01	77,136	303,591		1.00
	TOTALS		77,136	303,591		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,435,325		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,928,315		2.00
3.00	OPERATING ROOM	50.00	0	52,830		3.00
	TOTALS		0	6,416,470		
	G - DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,595,850		1.00
	TOTALS		0	3,595,850		
	H - LABOR AND DELIVERY COSTS					
1.00	NURSERY	43.00	102,901	56,647		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	131,456		2.00
	TOTALS		102,901	188,103		
	J - NURSING ADMIN COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	852,208	126,055		1.00
	TOTALS		852,208	126,055		
	K - MISCELLANEOUS DEPARTMENTS					
1.00	OPERATING ROOM	50.00	321,105	39,087		1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	52,956	741,892		2.00
3.00	EMERGENCY	91.00	56,777	141,890		3.00
	TOTALS		430,838	922,869		
	M - PORTION OF DIETARY COST TO CAFETERIA					
1.00	CAFETERIA	11.00	242,596	302,469		1.00
	TOTALS		242,596	302,469		
500.00	Grand Total: Increases		1,705,679	19,299,059		500.00

RECLASSIFICATIONS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-6 | Date/Time Prepared: 9/25/2015 7:15 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,245,752	0		1.00
	TOTALS		0	4,245,752			
	B - OXYGEN COSTS						
1.00	RESPIRATORY THERAPY	65.00	0	34,585	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	261	0		2.00
3.00	WOUND CARE	76.03	0	11,397	0		3.00
	TOTALS		0	46,243			
	C - RENTAL AND LEASES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,250,701	10		1.00
2.00	PHARMACY	15.00	0	106,298	10		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	9,582	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	802	0		4.00
5.00	OPERATING ROOM	50.00	0	467,271	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	248	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	190,901	0		7.00
8.00	ULTRASOUND	54.01	0	58,401	0		8.00
9.00	LABORATORY	60.00	0	55,458	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	22,953	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	41,474	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	105	0		12.00
13.00	WOUND CARE	76.03	0	8,548	0		13.00
	TOTALS		0	2,212,742			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	938,915	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	938,915			
	E - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	77,136	303,591	0		1.00
	TOTALS		77,136	303,591			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	6,000,521	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	1,719	0		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	414,230	0		3.00
	TOTALS		0	6,416,470			
	G - DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	3,595,850	0		1.00
	TOTALS		0	3,595,850			
	H - LABOR AND DELIVERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	42,939	188,103	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	59,962	0	0		2.00
	TOTALS		102,901	188,103			
	J - NURSING ADMIN COSTS						
1.00	NURSING ADMINISTRATION	13.00	852,208	126,055	0		1.00
	TOTALS		852,208	126,055			
	K - MISCELLANEOUS DEPARTMENTS						
1.00	RECOVERY ROOM	51.00	321,105	39,087	0		1.00
2.00	LABORATORY	60.00	52,956	741,892	0		2.00
3.00	AMBULANCE SERVICES	95.00	56,777	141,890	0		3.00
	TOTALS		430,838	922,869			
	M - PORTION OF DIETARY COST TO CAFETERIA						
1.00	DIETARY	10.00	242,596	302,469	0		1.00
	TOTALS		242,596	302,469			
500.00	Grand Total: Decreases		1,705,679	19,299,059			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 9/25/2015 7:15 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,393,860	0	0	0	0	1.00
2.00	Land Improvements	562,648	0	0	0	0	2.00
3.00	Buildings and Fixtures	46,966,867	7,927	0	7,927	0	3.00
4.00	Building Improvements	3,090,942	384,068	0	384,068	0	4.00
5.00	Fixed Equipment	2,282,249	12,089	0	12,089	15,815	5.00
6.00	Movable Equipment	24,643,261	1,578,997	0	1,578,997	1,756,841	6.00
7.00	HIT designated Assets	6,323,263	232,998	0	232,998	0	7.00
8.00	Subtotal (sum of lines 1-7)	85,263,090	2,216,079	0	2,216,079	1,772,656	8.00
9.00	Reconciling Items	-365,710	-48,474	0	-48,474	-301,329	9.00
10.00	Total (line 8 minus line 9)	85,628,800	2,264,553	0	2,264,553	2,073,985	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,393,860	0	1.00
2.00	Land Improvements	562,648	0	2.00
3.00	Buildings and Fixtures	46,974,794	0	3.00
4.00	Building Improvements	3,475,010	0	4.00
5.00	Fixed Equipment	2,278,523	0	5.00
6.00	Movable Equipment	24,465,417	0	6.00
7.00	HIT designated Assets	6,556,261	0	7.00
8.00	Subtotal (sum of lines 1-7)	85,706,513	0	8.00
9.00	Reconciling Items	-112,855	0	9.00
10.00	Total (line 8 minus line 9)	85,819,368	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 9/25/2015 7:15 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,152,499	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,122,735	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,275,234	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	1,152,499		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,122,735		2.00
3.00	Total (sum of lines 1-2)	0	5,275,234		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 9/25/2015 7:15 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	52,406,313	0	52,406,313	0.611462	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	33,300,201	0	33,300,201	0.388538	0	2.00
3.00	Total (sum of lines 1-2)	85,706,514	0	85,706,514	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	1,522,955	1,146,318	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,084,265	1,048,453	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,607,220	2,194,771	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	244,812	90,410	842,942	0	3,847,437	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	86,363	5,563	0	0	4,224,644	2.00
3.00	Total (sum of lines 1-2)	331,175	95,973	842,942	0	8,072,081	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8 | Date/Time Prepared: 9/25/2015 7:15 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		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)	B	-17,971	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	B	-38,425	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-8,476,217			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-2,150	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	14,264,401			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-410,278	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	B	-70	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-5,122	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,416	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	B	160	NURSING ADMINISTRATION	13.00	0	19.00
20.00	Vending machines	B	-4,178	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	366,367	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,038,423	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS REVENUE	A	-24,928	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	EMPLOYEE GIFTS	A	-30,151	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8 | Date/Time Prepared: 9/25/2015 7:15 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	HOSPITAL BAD DEBT	A	-6,827,040	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PATIENT PHONE BENEFIT EXPENSE	A	-2,736	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	PATIENT PHONE DEPRECIATION EXPENSE	A	-5,371	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.04
33.05	PATIENT TV DEPRECIATION EXPENSE	A	-23,716	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06	MARKETING EXPENSES	A	-178,607	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	DOJ SETTLEMENT	A	-1,822,149	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	PHYSICIAN RECRUITING	A	-267,056	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	LOBBYING EXPENSE	A	-49,582	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	CHARITABLE CONTRIBUTIONS	A	-21,738	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	GIFT SHOP	A	-1,138	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	ILLINOIS PROVIDER TAX	A	-3,494,312	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	CRNA COST	A	-85,279	ANESTHESIOLOGY	53.00	0	33.13
33.14	LEGAL COSTS	A	-55,544	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	PENALTIES/LATE CHARGES	A	-2,386	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	SPECIAL EVENTS	A	-1,575	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	POLITICAL CONTRIBUTIONS	A	-9,763	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	LATE CHARGES	A	31,032	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	PATIENT TV CABLE EXPENSE	A	-12,591	OPERATION OF PLANT	7.00	0	33.19
33.20	TELEVISION RENTAL	B	-120	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21			0		0.00	0	33.21
33.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.22
33.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,248,072				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: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 9/25/2015 7:15 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL RELAT INTEREST	194,554	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	524,635	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS	33,521	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAP BLDG & FIXTURES	16,737	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL MOVEABLE EQUIP	111,115	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	NON CAPITAL HOME OFFICE COST	1,603,071	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	5,082,200	226,569	4.03
4.04	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	58,025	82,777	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	-10,073,717	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	1,051,448	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	3,296	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	56,991	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	MIS FEES	0	457,004	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	MANAGED CARE	0	26,081	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	CASE MANAGEMENT	0	123,458	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	PURCHASE AND ANCILLARY	0	7,100	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	EMERGENCY ROOM	0	73,853	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	24,420	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	COMPLIANCE/HIM/CCA FEES	0	32,861	4.15
4.16	5.00	ADMINISTRATIVE & GENERAL	SENIOR CIRCLE	0	20,919	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	PASI COLLECTION FEES	0	606,812	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	EBOS FEES	0	82,121	4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN COLLECTION FEES	0	102,631	4.19
4.20	1.00	CAP REL COSTS-BLDG & FIXT	PRE-ACQUISITION LEGACY COSTS	4,089	0	4.20
4.21	2.00	CAP REL COSTS-MVBLE EQUIP	PRE-ACQUISITION LEGACY COSTS	24,143	0	4.21
4.22	5.00	ADMINISTRATIVE & GENERAL	PRE-ACQUISITION LEGACY COSTS	250,851	0	4.22
4.23	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS	4,897	0	4.23
4.24	5.00	ADMINISTRATIVE & GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	738,813	4.24
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,907,838	-6,356,563	5.00

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

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

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

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

6.00	B		0.00	CHS, INC	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140184	Period: From 05/01/2014 To 04/30/2015	Worksheet A-8-1 Date/Time Prepared: 9/25/2015 7:15 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	194,554	11		1.00
2.00	524,635	0		2.00
3.00	33,521	11		3.00
4.00	16,737	11		4.00
4.01	111,115	11		4.01
4.02	1,603,071	0		4.02
4.03	4,855,631	0		4.03
4.04	-24,752	11		4.04
4.05	10,073,717	0		4.05
4.06	-1,051,448	0		4.06
4.07	-3,296	0		4.07
4.08	-56,991	0		4.08
4.09	-457,004	0		4.09
4.10	-26,081	0		4.10
4.11	-123,458	0		4.11
4.12	-7,100	0		4.12
4.13	-73,853	0		4.13
4.14	-24,420	0		4.14
4.15	-32,861	0		4.15
4.16	-20,919	0		4.16
4.17	-606,812	0		4.17
4.18	-82,121	0		4.18
4.19	-102,631	0		4.19
4.20	4,089	9		4.20
4.21	24,143	9		4.21
4.22	250,851	0		4.22
4.23	4,897	9		4.23
4.24	-738,813	0		4.24
5.00	14,264,401			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	HOSPITAL CORPOR		6.00
7.00	COLLECTION AGEN		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 9/25/2015 7:15 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	601,085	601,085	0	0	0	1.00
2.00	50.00	OPERATING ROOM	920,347	920,347	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	4,140,100	4,140,100	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	675,374	675,374	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	533,376	533,376	0	0	0	5.00
6.00	76.01	SLEEP LAB	208,406	208,406	0	0	0	6.00
7.00	91.00	EMERGENCY	1,397,529	1,397,529	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			8,476,217	8,476,217	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	76.01	SLEEP LAB	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	601,085		1.00
2.00	50.00	OPERATING ROOM	0	0	0	920,347		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	4,140,100		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	675,374		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	533,376		5.00
6.00	76.01	SLEEP LAB	0	0	0	208,406		6.00
7.00	91.00	EMERGENCY	0	0	0	1,397,529		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	8,476,217		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,847,437	3,847,437				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,224,644		4,224,644			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,597,164	19,747	21,683	4,638,594		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,235,848	389,790	428,005	714,263	15,767,906	5.00
7.00	00700	OPERATION OF PLANT	2,256,648	836,209	918,189	70,175	4,081,221	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	321,792	8,108	8,903	8,254	347,057	8.00
9.00	00900	HOUSEKEEPING	1,112,839	21,986	24,142	167,676	1,326,643	9.00
10.00	01000	DIETARY	956,330	59,911	65,785	86,898	1,168,924	10.00
11.00	01100	CAFETERIA	134,787	67,709	74,347	49,566	326,409	11.00
13.00	01300	NURSING ADMINISTRATION	799,415	93,340	102,492	137,445	1,132,692	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	402,535	38,104	41,840	29,149	511,628	14.00
15.00	01500	PHARMACY	1,080,933	34,655	38,053	197,420	1,351,061	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,202,679	56,070	61,567	80,423	1,400,739	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,293,568	604,702	663,987	699,802	6,262,059	30.00
31.00	03100	INTENSIVE CARE UNIT	1,630,831	200,150	219,773	280,788	2,331,542	31.00
43.00	04300	NURSERY	456,848	32,465	35,648	68,591	593,552	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,688,451	335,584	368,485	353,536	4,746,056	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,177,027	78,301	85,978	192,983	1,534,289	52.00
53.00	05300	ANESTHESIOLOGY	159,978	9,726	10,680	0	180,384	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,600,383	119,168	130,852	339,187	3,189,590	54.00
54.01	05401	ULTRASOUND	176,964	34,099	37,443	32,911	281,417	54.01
56.00	05600	RADIOISOTOPE	475,822	11,296	12,403	30,057	529,578	56.00
57.00	05700	CT SCAN	278,861	19,649	21,575	44,115	364,200	57.00
58.00	05800	MRI	81,136	20,875	22,921	14,270	139,202	58.00
60.00	06000	LABORATORY	2,359,635	77,451	85,045	185,733	2,707,864	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	794,848	4,119	4,523	10,820	814,310	62.00
65.00	06500	RESPIRATORY THERAPY	608,226	17,736	19,475	100,756	746,193	65.00
66.00	06600	PHYSICAL THERAPY	669,910	106,990	117,479	118,407	1,012,786	66.00
67.00	06700	OCCUPATIONAL THERAPY	138,694	2,697	2,962	25,994	170,347	67.00
68.00	06800	SPEECH PATHOLOGY	74,738	1,520	1,669	14,158	92,085	68.00
69.00	06900	ELECTROCARDIOLOGY	2,094,713	68,493	75,208	213,519	2,451,933	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,481,498	0	0	0	1,481,498	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,928,315	0	0	0	4,928,315	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,590,728	0	0	0	3,590,728	73.00
74.00	07400	RENAL DIALYSIS	233,439	5,460	5,995	0	244,894	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	8,533	38,513	42,289	0	89,335	76.01
76.03	03951	WOUND CARE	291,571	46,000	50,510	39,025	427,106	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,251,168	155,916	171,202	305,922	2,884,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,718,936	3,616,539	3,971,108	4,611,843	69,207,751	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,050	12,134	0	23,184	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3	215,778	236,933	0	452,714	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	65,426	4,070	4,469	10,991	84,956	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	380,727	0	0	15,760	396,487	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
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)	70,165,092	3,847,437	4,224,644	4,638,594	70,165,092	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,767,906					5.00
7.00	00700	OPERATION OF PLANT	1,183,007	5,264,228				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	100,600	16,406	464,063			8.00
9.00	00900	HOUSEKEEPING	384,549	44,487	0	1,755,679		9.00
10.00	01000	DIETARY	338,831	121,223	0	40,902	1,669,880	10.00
11.00	01100	CAFETERIA	94,615	137,000	0	46,226	987,799	11.00
13.00	01300	NURSING ADMINISTRATION	328,329	188,863	0	63,725	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	148,304	77,100	0	26,015	0	14.00
15.00	01500	PHARMACY	391,627	70,121	0	23,660	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	406,027	113,450	0	38,280	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,815,168	1,223,545	137,162	412,841	387,629	30.00
31.00	03100	INTENSIVE CARE UNIT	675,835	404,981	31,090	136,646	59,438	31.00
43.00	04300	NURSERY	172,051	65,689	0	22,164	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,375,720	679,015	78,182	229,109	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	444,738	158,434	67,209	53,458	0	52.00
53.00	05300	ANESTHESIOLOGY	52,287	19,680	5,944	6,640	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	924,554	241,123	21,946	81,358	0	54.00
54.01	05401	ULTRASOUND	81,573	68,996	0	23,280	0	54.01
56.00	05600	RADIOISOTOPE	153,507	22,855	0	7,712	0	56.00
57.00	05700	CT SCAN	105,569	39,757	0	13,415	0	57.00
58.00	05800	MRI	40,350	42,238	0	14,252	0	58.00
60.00	06000	LABORATORY	784,918	156,714	0	52,877	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	236,041	8,335	0	2,812	0	62.00
65.00	06500	RESPIRATORY THERAPY	216,296	35,887	0	12,109	0	65.00
66.00	06600	PHYSICAL THERAPY	293,572	216,482	7,772	73,044	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,378	5,458	0	1,841	0	67.00
68.00	06800	SPEECH PATHOLOGY	26,692	3,076	0	1,038	0	68.00
69.00	06900	ELECTROCARDIOLOGY	710,732	138,588	26,975	46,762	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	429,436	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,428,551	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,040,830	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	70,986	11,047	0	3,728	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	25,895	77,927	2,743	26,294	0	76.01
76.03	03951	WOUND CARE	123,804	93,076	914	31,405	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	836,034	315,478	83,669	106,447	9,656	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,490,406	4,797,031	463,606	1,598,040	1,444,522	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,720	22,359	0	7,544	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	131,226	436,602	457	147,316	973	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	24,626	8,236	0	2,779	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	114,928	0	0	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	224,385	194.02
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)	15,767,906	5,264,228	464,063	1,755,679	1,669,880	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,592,049					11.00
13.00	01300	NURSING ADMINISTRATION	36,434	1,750,043				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	29,986	0	793,033			14.00
15.00	01500	PHARMACY	57,771	0	2,155	1,896,395		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	64,900	0	919	0	2,024,315	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	336,978	451,002	45,617	0	146,708	30.00
31.00	03100	INTENSIVE CARE UNIT	102,173	180,961	9,178	0	29,957	31.00
43.00	04300	NURSERY	28,676	44,205	3,378	0	9,505	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	170,167	227,845	102,507	0	317,774	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	84,612	124,372	897	0	16,092	52.00
53.00	05300	ANESTHESIOLOGY	0	0	9,269	0	53,843	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,394	218,597	14,281	0	52,642	54.00
54.01	05401	ULTRASOUND	13,053	21,210	197	0	17,050	54.01
56.00	05600	RADIOISOTOPE	10,380	19,371	195	0	67,005	56.00
57.00	05700	CT SCAN	21,598	28,431	3,365	0	112,556	57.00
58.00	05800	MRI	6,029	9,197	418	0	22,991	58.00
60.00	06000	LABORATORY	127,232	0	44,648	0	279,913	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,662	0	2,821	0	18,035	62.00
65.00	06500	RESPIRATORY THERAPY	51,427	64,935	4,673	0	43,407	65.00
66.00	06600	PHYSICAL THERAPY	49,488	0	1,852	0	30,782	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,485	0	0	0	6,594	67.00
68.00	06800	SPEECH PATHOLOGY	4,299	0	11	0	2,906	68.00
69.00	06900	ELECTROCARDIOLOGY	95,568	137,608	32,900	0	254,166	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	106,352	0	47,274	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	365,170	0	123,817	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,896,395	170,903	73.00
74.00	07400	RENAL DIALYSIS	0	0	9	0	5,970	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	629	0	5,636	76.01
76.03	03951	WOUND CARE	18,925	25,150	3,803	0	5,048	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	117,062	197,159	37,716	0	183,741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,582,299	1,750,043	792,960	1,896,395	2,024,315	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	5,242	0	35	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	4,508	0	38	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
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)	1,592,049	1,750,043	793,033	1,896,395	2,024,315	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I | Date/Time Prepared: 9/25/2015 7:15 am

		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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	11,218,709	0	11,218,709		30.00
31.00	03100	INTENSIVE CARE UNIT	3,961,801	0	3,961,801		31.00
43.00	04300	NURSERY	939,220	0	939,220		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	7,926,375	0	7,926,375		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,484,101	0	2,484,101		52.00
53.00	05300	ANESTHESIOLOGY	328,047	0	328,047		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,883,485	0	4,883,485		54.00
54.01	05401	ULTRASOUND	506,776	0	506,776		54.01
56.00	05600	RADIOISOTOPE	810,603	0	810,603		56.00
57.00	05700	CT SCAN	688,891	0	688,891		57.00
58.00	05800	MRI	274,677	0	274,677		58.00
60.00	06000	LABORATORY	4,154,166	0	4,154,166		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,088,016	0	1,088,016		62.00
65.00	06500	RESPIRATORY THERAPY	1,174,927	0	1,174,927		65.00
66.00	06600	PHYSICAL THERAPY	1,685,778	0	1,685,778		66.00
67.00	06700	OCCUPATIONAL THERAPY	244,103	0	244,103		67.00
68.00	06800	SPEECH PATHOLOGY	130,107	0	130,107		68.00
69.00	06900	ELECTROCARDIOLOGY	3,895,232	0	3,895,232		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,064,560	0	2,064,560		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,845,853	0	6,845,853		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,698,856	0	6,698,856		73.00
74.00	07400	RENAL DIALYSIS	336,634	0	336,634		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	228,459	0	228,459		76.01
76.03	03951	WOUND CARE	729,231	0	729,231		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	4,771,170	0	4,771,170		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	68,069,777	0	68,069,777		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	59,807	0	59,807		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,169,288	0	1,169,288		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	SENIOR CIRCLE	125,874	0	125,874		193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0		194.00
194.01	07953	MARKETING	515,961	0	515,961		194.01
194.02	07952	NON ALLOWABLE MEALS	224,385	0	224,385		194.02
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)	70,165,092	0	70,165,092		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	19,747	21,683	41,430	41,430	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	389,790	428,005	817,795	6,376	5.00
7.00	00700	OPERATION OF PLANT	0	836,209	918,189	1,754,398	627	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,108	8,903	17,011	74	8.00
9.00	00900	HOUSEKEEPING	0	21,986	24,142	46,128	1,498	9.00
10.00	01000	DIETARY	0	59,911	65,785	125,696	776	10.00
11.00	01100	CAFETERIA	0	67,709	74,347	142,056	443	11.00
13.00	01300	NURSING ADMINISTRATION	0	93,340	102,492	195,832	1,228	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	38,104	41,840	79,944	260	14.00
15.00	01500	PHARMACY	0	34,655	38,053	72,708	1,763	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	56,070	61,567	117,637	718	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	604,702	663,987	1,268,689	6,251	30.00
31.00	03100	INTENSIVE CARE UNIT	0	200,150	219,773	419,923	2,508	31.00
43.00	04300	NURSERY	0	32,465	35,648	68,113	613	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	335,584	368,485	704,069	3,158	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	78,301	85,978	164,279	1,724	52.00
53.00	05300	ANESTHESIOLOGY	0	9,726	10,680	20,406	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	119,168	130,852	250,020	3,030	54.00
54.01	05401	ULTRASOUND	0	34,099	37,443	71,542	294	54.01
56.00	05600	RADIOISOTOPE	0	11,296	12,403	23,699	268	56.00
57.00	05700	CT SCAN	0	19,649	21,575	41,224	394	57.00
58.00	05800	MRI	0	20,875	22,921	43,796	127	58.00
60.00	06000	LABORATORY	0	77,451	85,045	162,496	1,659	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,119	4,523	8,642	97	62.00
65.00	06500	RESPIRATORY THERAPY	0	17,736	19,475	37,211	900	65.00
66.00	06600	PHYSICAL THERAPY	0	106,990	117,479	224,469	1,058	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,697	2,962	5,659	232	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,520	1,669	3,189	126	68.00
69.00	06900	ELECTROCARDIOLOGY	0	68,493	75,208	143,701	1,907	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	5,460	5,995	11,455	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	38,513	42,289	80,802	0	76.01
76.03	03951	WOUND CARE	0	46,000	50,510	96,510	349	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	155,916	171,202	327,118	2,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,616,539	3,971,108	7,587,647	41,191	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,050	12,134	23,184	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	215,778	236,933	452,711	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	4,070	4,469	8,539	98	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	141	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
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	3,847,437	4,224,644	8,072,081	41,430	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	824,171					5.00
7.00	00700	OPERATION OF PLANT	61,835	1,816,860				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,258	5,662	28,005			8.00
9.00	00900	HOUSEKEEPING	20,100	15,354	0	83,080		9.00
10.00	01000	DIETARY	17,710	41,838	0	1,936	187,956	10.00
11.00	01100	CAFETERIA	4,945	47,283	0	2,187	111,183	11.00
13.00	01300	NURSING ADMINISTRATION	17,161	65,183	0	3,016	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,752	26,610	0	1,231	0	14.00
15.00	01500	PHARMACY	20,470	24,201	0	1,120	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,223	39,155	0	1,811	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	94,876	422,285	8,277	19,537	43,630	30.00
31.00	03100	INTENSIVE CARE UNIT	35,325	139,773	1,876	6,466	6,690	31.00
43.00	04300	NURSERY	8,993	22,671	0	1,049	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	71,907	234,351	4,718	10,842	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,246	54,681	4,056	2,530	0	52.00
53.00	05300	ANESTHESIOLOGY	2,733	6,792	359	314	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,325	83,220	1,324	3,850	0	54.00
54.01	05401	ULTRASOUND	4,264	23,813	0	1,102	0	54.01
56.00	05600	RADIOISOTOPE	8,024	7,888	0	365	0	56.00
57.00	05700	CT SCAN	5,518	13,722	0	635	0	57.00
58.00	05800	MRI	2,109	14,578	0	674	0	58.00
60.00	06000	LABORATORY	41,027	54,087	0	2,502	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,338	2,877	0	133	0	62.00
65.00	06500	RESPIRATORY THERAPY	11,306	12,386	0	573	0	65.00
66.00	06600	PHYSICAL THERAPY	15,345	74,715	469	3,456	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,581	1,884	0	87	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,395	1,062	0	49	0	68.00
69.00	06900	ELECTROCARDIOLOGY	37,149	47,831	1,628	2,213	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,446	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	74,669	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	54,403	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,710	3,813	0	176	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,354	26,895	166	1,244	0	76.01
76.03	03951	WOUND CARE	6,471	32,123	55	1,486	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	43,699	108,882	5,049	5,037	1,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	809,667	1,655,615	27,977	75,621	162,590	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	351	7,717	0	357	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,859	150,686	28	6,971	110	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	1,287	2,842	0	131	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	6,007	0	0	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	25,256	194.02
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)	824,171	1,816,860	28,005	83,080	187,956	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	308,097					11.00
13.00	01300	NURSING ADMINISTRATION	7,051	289,471				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,803	0	121,600			14.00
15.00	01500	PHARMACY	11,180	0	330	131,772		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,560	0	141	0	193,245	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,212	74,601	6,995	0	14,022	30.00
31.00	03100	INTENSIVE CARE UNIT	19,773	29,932	1,407	0	2,863	31.00
43.00	04300	NURSERY	5,549	7,312	518	0	908	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,931	37,687	15,719	0	30,136	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,374	20,572	138	0	1,538	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,421	0	5,146	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,976	36,158	2,190	0	5,031	54.00
54.01	05401	ULTRASOUND	2,526	3,508	30	0	1,630	54.01
56.00	05600	RADIOISOTOPE	2,009	3,204	30	0	6,404	56.00
57.00	05700	CT SCAN	4,180	4,703	516	0	10,758	57.00
58.00	05800	MRI	1,167	1,521	64	0	2,197	58.00
60.00	06000	LABORATORY	24,622	0	6,846	0	26,754	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,096	0	433	0	1,724	62.00
65.00	06500	RESPIRATORY THERAPY	9,952	10,741	717	0	4,149	65.00
66.00	06600	PHYSICAL THERAPY	9,577	0	284	0	2,942	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,029	0	0	0	630	67.00
68.00	06800	SPEECH PATHOLOGY	832	0	2	0	278	68.00
69.00	06900	ELECTROCARDIOLOGY	18,495	22,761	5,045	0	24,293	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	16,308	0	4,518	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	55,992	0	11,834	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	131,772	16,335	73.00
74.00	07400	RENAL DIALYSIS	0	0	1	0	571	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	96	0	539	76.01
76.03	03951	WOUND CARE	3,662	4,160	583	0	483	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	22,654	32,611	5,783	0	17,562	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	306,210	289,471	121,589	131,772	193,245	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	1,015	0	5	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	872	0	6	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
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)	308,097	289,471	121,600	131,772	193,245	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/25/2015 7:15 am

		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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,024,375	0	2,024,375		30.00
31.00	03100	INTENSIVE CARE UNIT	666,536	0	666,536		31.00
43.00	04300	NURSERY	115,726	0	115,726		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,145,518	0	1,145,518		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	289,138	0	289,138		52.00
53.00	05300	ANESTHESIOLOGY	37,171	0	37,171		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	460,124	0	460,124		54.00
54.01	05401	ULTRASOUND	108,709	0	108,709		54.01
56.00	05600	RADIOISOTOPE	51,891	0	51,891		56.00
57.00	05700	CT SCAN	81,650	0	81,650		57.00
58.00	05800	MRI	66,233	0	66,233		58.00
60.00	06000	LABORATORY	319,993	0	319,993		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	27,340	0	27,340		62.00
65.00	06500	RESPIRATORY THERAPY	87,935	0	87,935		65.00
66.00	06600	PHYSICAL THERAPY	332,315	0	332,315		66.00
67.00	06700	OCCUPATIONAL THERAPY	13,102	0	13,102		67.00
68.00	06800	SPEECH PATHOLOGY	6,933	0	6,933		68.00
69.00	06900	ELECTROCARDIOLOGY	305,023	0	305,023		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,272	0	43,272		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	142,495	0	142,495		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	202,510	0	202,510		73.00
74.00	07400	RENAL DIALYSIS	19,726	0	19,726		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	111,096	0	111,096		76.01
76.03	03951	WOUND CARE	145,882	0	145,882		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	572,215	0	572,215		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,376,908	0	7,376,908		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,609	0	31,609		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	617,365	0	617,365		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	SENIOR CIRCLE	13,917	0	13,917		193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0		194.00
194.01	07953	MARKETING	7,026	0	7,026		194.01
194.02	07952	NON ALLOWABLE MEALS	25,256	0	25,256		194.02
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)	8,072,081	0	8,072,081		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	235,363					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		235,363				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,208	1,208	22,703,238			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,845	23,845	3,495,884	-15,767,906	54,397,186	5.00
7.00	00700	OPERATION OF PLANT	51,154	51,154	343,467	0	4,081,221	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496	496	40,398	0	347,057	8.00
9.00	00900	HOUSEKEEPING	1,345	1,345	820,680	0	1,326,643	9.00
10.00	01000	DIETARY	3,665	3,665	425,316	0	1,168,924	10.00
11.00	01100	CAFETERIA	4,142	4,142	242,596	0	326,409	11.00
13.00	01300	NURSING ADMINISTRATION	5,710	5,710	672,714	0	1,132,692	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	2,331	142,668	0	511,628	14.00
15.00	01500	PHARMACY	2,120	2,120	966,260	0	1,351,061	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,430	3,430	393,624	0	1,400,739	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,992	36,992	3,425,128	0	6,262,059	30.00
31.00	03100	INTENSIVE CARE UNIT	12,244	12,244	1,374,298	0	2,331,542	31.00
43.00	04300	NURSERY	1,986	1,986	335,714	0	593,552	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,529	20,529	1,730,356	0	4,746,056	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,790	4,790	944,541	0	1,534,289	52.00
53.00	05300	ANESTHESIOLOGY	595	595	0	0	180,384	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,290	7,290	1,660,125	0	3,189,590	54.00
54.01	05401	ULTRASOUND	2,086	2,086	161,081	0	281,417	54.01
56.00	05600	RADIOISOTOPE	691	691	147,112	0	529,578	56.00
57.00	05700	CT SCAN	1,202	1,202	215,919	0	364,200	57.00
58.00	05800	MRI	1,277	1,277	69,843	0	139,202	58.00
60.00	06000	LABORATORY	4,738	4,738	909,055	0	2,707,864	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	252	52,956	0	814,310	62.00
65.00	06500	RESPIRATORY THERAPY	1,085	1,085	493,145	0	746,193	65.00
66.00	06600	PHYSICAL THERAPY	6,545	6,545	579,532	0	1,012,786	66.00
67.00	06700	OCCUPATIONAL THERAPY	165	165	127,224	0	170,347	67.00
68.00	06800	SPEECH PATHOLOGY	93	93	69,297	0	92,085	68.00
69.00	06900	ELECTROCARDIOLOGY	4,190	4,190	1,045,055	0	2,451,933	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,481,498	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,928,315	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,590,728	73.00
74.00	07400	RENAL DIALYSIS	334	334	0	0	244,894	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,356	2,356	0	0	89,335	76.01
76.03	03951	WOUND CARE	2,814	2,814	191,003	0	427,106	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,538	9,538	1,497,314	0	2,884,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	221,238	221,238	22,572,305	-15,767,906	53,439,845	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	676	676	0	0	23,184	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,200	13,200	0	0	452,714	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	249	249	53,797	0	84,956	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	77,136	0	396,487	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
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)	3,847,437	4,224,644	4,638,594		15,767,906	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.346822	17.949482	0.204314		0.289866	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			41,430		824,171	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001825		0.015151	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	159,156					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496	1,015				8.00
9.00	00900	HOUSEKEEPING	1,345	0	157,315			9.00
10.00	01000	DIETARY	3,665	0	3,665	157,890		10.00
11.00	01100	CAFETERIA	4,142	0	4,142	93,398	30,369	11.00
13.00	01300	NURSING ADMINISTRATION	5,710	0	5,710	0	695	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	0	2,331	0	572	14.00
15.00	01500	PHARMACY	2,120	0	2,120	0	1,102	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,430	0	3,430	0	1,238	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,992	300	36,992	36,651	6,428	30.00
31.00	03100	INTENSIVE CARE UNIT	12,244	68	12,244	5,620	1,949	31.00
43.00	04300	NURSERY	1,986	0	1,986	0	547	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,529	171	20,529	0	3,246	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,790	147	4,790	0	1,614	52.00
53.00	05300	ANESTHESIOLOGY	595	13	595	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,290	48	7,290	0	2,659	54.00
54.01	05401	ULTRASOUND	2,086	0	2,086	0	249	54.01
56.00	05600	RADIOISOTOPE	691	0	691	0	198	56.00
57.00	05700	CT SCAN	1,202	0	1,202	0	412	57.00
58.00	05800	MRI	1,277	0	1,277	0	115	58.00
60.00	06000	LABORATORY	4,738	0	4,738	0	2,427	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	0	252	0	108	62.00
65.00	06500	RESPIRATORY THERAPY	1,085	0	1,085	0	981	65.00
66.00	06600	PHYSICAL THERAPY	6,545	17	6,545	0	944	66.00
67.00	06700	OCCUPATIONAL THERAPY	165	0	165	0	200	67.00
68.00	06800	SPEECH PATHOLOGY	93	0	93	0	82	68.00
69.00	06900	ELECTROCARDIOLOGY	4,190	59	4,190	0	1,823	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	334	0	334	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,356	6	2,356	0	0	76.01
76.03	03951	WOUND CARE	2,814	2	2,814	0	361	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,538	183	9,538	913	2,233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	145,031	1,014	143,190	136,582	30,183	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	676	0	676	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,200	1	13,200	92	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	249	0	249	0	100	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	86	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	21,216	0	194.02
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)	5,264,228	464,063	1,755,679	1,669,880	1,592,049	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.075900	457.204926	11.160277	10.576224	52.423491	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,816,860	28,005	83,080	187,956	308,097	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	11.415592	27.591133	0.528112	1.190424	10.145115	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/25/2015 7:15 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	13,290,635					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,702,762				14.00
15.00	01500	PHARMACY	0	29,084	3,595,850			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,403	0	556,003,673		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,425,128	615,651	0	40,293,332		30.00
31.00	03100	INTENSIVE CARE UNIT	1,374,298	123,868	0	8,227,804		31.00
43.00	04300	NURSERY	335,714	45,595	0	2,610,466		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,730,357	1,383,439	0	87,303,089		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	944,541	12,110	0	4,419,750		52.00
53.00	05300	ANESTHESIOLOGY	0	125,097	0	14,788,027		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,660,125	192,741	0	14,458,006		54.00
54.01	05401	ULTRASOUND	161,081	2,663	0	4,682,721		54.01
56.00	05600	RADIOISOTOPE	147,112	2,630	0	18,402,951		56.00
57.00	05700	CT SCAN	215,919	45,418	0	30,913,525		57.00
58.00	05800	MRI	69,843	5,637	0	6,314,396		58.00
60.00	06000	LABORATORY	0	602,574	0	76,877,928		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	38,071	0	4,953,290		62.00
65.00	06500	RESPIRATORY THERAPY	493,145	63,071	0	11,921,667		65.00
66.00	06600	PHYSICAL THERAPY	0	24,989	0	8,454,178		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,810,912		67.00
68.00	06800	SPEECH PATHOLOGY	0	142	0	798,003		68.00
69.00	06900	ELECTROCARDIOLOGY	1,045,055	444,016	0	69,806,632		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,435,325	0	12,983,680		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,928,315	0	34,006,355		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,595,850	46,938,532		73.00
74.00	07400	RENAL DIALYSIS	0	116	0	1,639,761		74.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	8,488	0	1,547,800		76.01
76.03	03951	WOUND CARE	191,003	51,321	0	1,386,550		76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,497,314	509,018	0	50,464,318		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,290,635	10,701,782	3,595,850	556,003,673		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	SENIOR CIRCLE	0	469	0	0		193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0		194.00
194.01	07953	MARKETING	0	508	0	0		194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0		194.02
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)	1,750,043	793,033	1,896,395	2,024,315		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.131675	0.074096	0.527384	0.003641		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	289,471	121,600	131,772	193,245		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.021780	0.011362	0.036646	0.000348		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,218,709		11,218,709	0	11,218,709	30.00
31.00	03100	INTENSIVE CARE UNIT	3,961,801		3,961,801	0	3,961,801	31.00
43.00	04300	NURSERY	939,220		939,220	0	939,220	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,926,375		7,926,375	0	7,926,375	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,484,101		2,484,101	0	2,484,101	52.00
53.00	05300	ANESTHESIOLOGY	328,047		328,047	0	328,047	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,883,485		4,883,485	0	4,883,485	54.00
54.01	05401	ULTRASOUND	506,776		506,776	0	506,776	54.01
56.00	05600	RADIOISOTOPE	810,603		810,603	0	810,603	56.00
57.00	05700	CT SCAN	688,891		688,891	0	688,891	57.00
58.00	05800	MRI	274,677		274,677	0	274,677	58.00
60.00	06000	LABORATORY	4,154,166		4,154,166	0	4,154,166	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,088,016		1,088,016	0	1,088,016	62.00
65.00	06500	RESPIRATORY THERAPY	1,174,927	0	1,174,927	0	1,174,927	65.00
66.00	06600	PHYSICAL THERAPY	1,685,778	0	1,685,778	0	1,685,778	66.00
67.00	06700	OCCUPATIONAL THERAPY	244,103	0	244,103	0	244,103	67.00
68.00	06800	SPEECH PATHOLOGY	130,107	0	130,107	0	130,107	68.00
69.00	06900	ELECTROCARDIOLOGY	3,895,232		3,895,232	0	3,895,232	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,064,560		2,064,560	0	2,064,560	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,845,853		6,845,853	0	6,845,853	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,698,856		6,698,856	0	6,698,856	73.00
74.00	07400	RENAL DIALYSIS	336,634		336,634	0	336,634	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	228,459		228,459	0	228,459	76.01
76.03	03951	WOUND CARE	729,231		729,231	0	729,231	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,771,170		4,771,170	0	4,771,170	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,579,939		1,579,939		1,579,939	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
200.00		Subtotal (see instructions)	69,649,716	0	69,649,716	0	69,649,716	200.00
201.00		Less Observation Beds	1,579,939		1,579,939		1,579,939	201.00
202.00		Total (see instructions)	68,069,777	0	68,069,777	0	68,069,777	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,741,978		34,741,978			30.00
31.00	03100	INTENSIVE CARE UNIT	8,227,804		8,227,804			31.00
43.00	04300	NURSERY	2,610,466		2,610,466			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,274,261	52,028,828	87,303,089	0.090791	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,371,469	48,281	4,419,750	0.562046	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	7,396,943	7,391,084	14,788,027	0.022183	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,243,184	11,214,822	14,458,006	0.337770	0.000000	54.00
54.01	05401	ULTRASOUND	1,464,270	3,218,451	4,682,721	0.108223	0.000000	54.01
56.00	05600	RADIOISOTOPE	6,502,362	11,900,589	18,402,951	0.044047	0.000000	56.00
57.00	05700	CT SCAN	8,904,203	22,009,322	30,913,525	0.022284	0.000000	57.00
58.00	05800	MRI	1,152,584	5,161,812	6,314,396	0.043500	0.000000	58.00
60.00	06000	LABORATORY	33,637,648	43,240,280	76,877,928	0.054036	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,804,384	2,148,906	4,953,290	0.219655	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	9,801,198	2,120,469	11,921,667	0.098554	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,304,853	4,149,325	8,454,178	0.199402	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,386,942	423,970	1,810,912	0.134796	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	671,126	126,877	798,003	0.163041	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	41,549,168	28,257,464	69,806,632	0.055800	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,527,257	3,456,423	12,983,680	0.159012	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,940,407	10,065,948	34,006,355	0.201311	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,474,814	24,463,718	46,938,532	0.142715	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,593,871	45,890	1,639,761	0.205295	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	46,100	1,501,700	1,547,800	0.147602	0.000000	76.01
76.03	03951	WOUND CARE	115,926	1,270,624	1,386,550	0.525932	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	11,899,953	38,564,365	50,464,318	0.094545	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,458,270	4,093,084	5,551,354	0.284604	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
200.00		Subtotal (see instructions)	279,101,441	276,902,232	556,003,673			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	279,101,441	276,902,232	556,003,673			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.090791	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.562046	52.00
53.00	05300	ANESTHESIOLOGY	0.022183	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337770	54.00
54.01	05401	ULTRASOUND	0.108223	54.01
56.00	05600	RADIOISOTOPE	0.044047	56.00
57.00	05700	CT SCAN	0.022284	57.00
58.00	05800	MRI	0.043500	58.00
60.00	06000	LABORATORY	0.054036	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.219655	62.00
65.00	06500	RESPIRATORY THERAPY	0.098554	65.00
66.00	06600	PHYSICAL THERAPY	0.199402	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.134796	67.00
68.00	06800	SPEECH PATHOLOGY	0.163041	68.00
69.00	06900	ELECTROCARDIOLOGY	0.055800	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.159012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.201311	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142715	73.00
74.00	07400	RENAL DIALYSIS	0.205295	74.00
76.00	03020	ACUPUNCTURE	0.000000	76.00
76.01	03610	SLEEP LAB	0.147602	76.01
76.03	03951	WOUND CARE	0.525932	76.03
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.094545	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284604	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
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: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/25/2015 7:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,218,709		11,218,709	0	11,218,709	30.00
31.00	03100	INTENSIVE CARE UNIT	3,961,801		3,961,801	0	3,961,801	31.00
43.00	04300	NURSERY	939,220		939,220	0	939,220	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,926,375		7,926,375	0	7,926,375	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,484,101		2,484,101	0	2,484,101	52.00
53.00	05300	ANESTHESIOLOGY	328,047		328,047	0	328,047	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,883,485		4,883,485	0	4,883,485	54.00
54.01	05401	ULTRASOUND	506,776		506,776	0	506,776	54.01
56.00	05600	RADIOISOTOPE	810,603		810,603	0	810,603	56.00
57.00	05700	CT SCAN	688,891		688,891	0	688,891	57.00
58.00	05800	MRI	274,677		274,677	0	274,677	58.00
60.00	06000	LABORATORY	4,154,166		4,154,166	0	4,154,166	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,088,016		1,088,016	0	1,088,016	62.00
65.00	06500	RESPIRATORY THERAPY	1,174,927	0	1,174,927	0	1,174,927	65.00
66.00	06600	PHYSICAL THERAPY	1,685,778	0	1,685,778	0	1,685,778	66.00
67.00	06700	OCCUPATIONAL THERAPY	244,103	0	244,103	0	244,103	67.00
68.00	06800	SPEECH PATHOLOGY	130,107	0	130,107	0	130,107	68.00
69.00	06900	ELECTROCARDIOLOGY	3,895,232		3,895,232	0	3,895,232	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,064,560		2,064,560	0	2,064,560	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,845,853		6,845,853	0	6,845,853	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,698,856		6,698,856	0	6,698,856	73.00
74.00	07400	RENAL DIALYSIS	336,634		336,634	0	336,634	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	228,459		228,459	0	228,459	76.01
76.03	03951	WOUND CARE	729,231		729,231	0	729,231	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,771,170		4,771,170	0	4,771,170	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,579,939		1,579,939		1,579,939	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
200.00		Subtotal (see instructions)	69,649,716	0	69,649,716	0	69,649,716	200.00
201.00		Less Observation Beds	1,579,939		1,579,939		1,579,939	201.00
202.00		Total (see instructions)	68,069,777	0	68,069,777	0	68,069,777	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/25/2015 7:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,741,978		34,741,978			30.00
31.00	03100	INTENSIVE CARE UNIT	8,227,804		8,227,804			31.00
43.00	04300	NURSERY	2,610,466		2,610,466			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,274,261	52,028,828	87,303,089	0.090791	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,371,469	48,281	4,419,750	0.562046	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	7,396,943	7,391,084	14,788,027	0.022183	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,243,184	11,214,822	14,458,006	0.337770	0.000000	54.00
54.01	05401	ULTRASOUND	1,464,270	3,218,451	4,682,721	0.108223	0.000000	54.01
56.00	05600	RADIOISOTOPE	6,502,362	11,900,589	18,402,951	0.044047	0.000000	56.00
57.00	05700	CT SCAN	8,904,203	22,009,322	30,913,525	0.022284	0.000000	57.00
58.00	05800	MRI	1,152,584	5,161,812	6,314,396	0.043500	0.000000	58.00
60.00	06000	LABORATORY	33,637,648	43,240,280	76,877,928	0.054036	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,804,384	2,148,906	4,953,290	0.219655	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	9,801,198	2,120,469	11,921,667	0.098554	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,304,853	4,149,325	8,454,178	0.199402	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,386,942	423,970	1,810,912	0.134796	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	671,126	126,877	798,003	0.163041	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	41,549,168	28,257,464	69,806,632	0.055800	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,527,257	3,456,423	12,983,680	0.159012	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,940,407	10,065,948	34,006,355	0.201311	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,474,814	24,463,718	46,938,532	0.142715	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,593,871	45,890	1,639,761	0.205295	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	46,100	1,501,700	1,547,800	0.147602	0.000000	76.01
76.03	03951	WOUND CARE	115,926	1,270,624	1,386,550	0.525932	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	11,899,953	38,564,365	50,464,318	0.094545	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,458,270	4,093,084	5,551,354	0.284604	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
200.00		Subtotal (see instructions)	279,101,441	276,902,232	556,003,673			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	279,101,441	276,902,232	556,003,673			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/25/2015 7:15 am

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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.03	03951	WOUND CARE	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
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: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part I Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,024,375	0	2,024,375	14,315	141.42	30.00
31.00	INTENSIVE CARE UNIT	666,536		666,536	1,886	353.41	31.00
43.00	NURSERY	115,726		115,726	1,645	70.35	43.00
200.00	Total (lines 30-199)	2,806,637		2,806,637	17,846		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,444	769,890				30.00
31.00	INTENSIVE CARE UNIT	1,048	370,374				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	6,492	1,140,264				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part II Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,145,518	87,303,089	0.013121	13,908,936	182,499	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	289,138	4,419,750	0.065420	16,920	1,107	52.00
53.00	05300	ANESTHESIOLOGY	37,171	14,788,027	0.002514	2,713,053	6,821	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	460,124	14,458,006	0.031825	1,783,485	56,759	54.00
54.01	05401	ULTRASOUND	108,709	4,682,721	0.023215	759,397	17,629	54.01
56.00	05600	RADIOISOTOPE	51,891	18,402,951	0.002820	3,321,590	9,367	56.00
57.00	05700	CT SCAN	81,650	30,913,525	0.002641	4,485,425	11,846	57.00
58.00	05800	MRI	66,233	6,314,396	0.010489	536,724	5,630	58.00
60.00	06000	LABORATORY	319,993	76,877,928	0.004162	16,735,604	69,654	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	27,340	4,953,290	0.005520	1,543,624	8,521	62.00
65.00	06500	RESPIRATORY THERAPY	87,935	11,921,667	0.007376	5,309,630	39,164	65.00
66.00	06600	PHYSICAL THERAPY	332,315	8,454,178	0.039308	2,609,548	102,576	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,102	1,810,912	0.007235	817,284	5,913	67.00
68.00	06800	SPEECH PATHOLOGY	6,933	798,003	0.008688	58,560	509	68.00
69.00	06900	ELECTROCARDIOLOGY	305,023	69,806,632	0.004370	20,995,470	91,750	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,272	12,983,680	0.003333	4,788,832	15,961	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	142,495	34,006,355	0.004190	11,488,321	48,136	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	202,510	46,938,532	0.004314	10,045,448	43,336	73.00
74.00	07400	RENAL DIALYSIS	19,726	1,639,761	0.012030	954,503	11,483	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	111,096	1,547,800	0.071777	8,000	574	76.01
76.03	03951	WOUND CARE	145,882	1,386,550	0.105212	7,023	739	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	572,215	50,464,318	0.011339	5,898,810	66,887	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	285,094	5,551,354	0.051356	687,607	35,313	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50-199)	4,855,365	510,423,425		109,473,794	832,174	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part III Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,315	0.00	5,444	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,886	0.00	1,048	0		31.00
43.00	04300	NURSERY	1,645	0.00	0	0		43.00
200.00		Total (lines 30-199)	17,846		6,492	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV | Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	87,303,089	0.000000	0.000000	13,908,936	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,419,750	0.000000	0.000000	16,920	52.00
53.00	05300	ANESTHESIOLOGY	0	14,788,027	0.000000	0.000000	2,713,053	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,458,006	0.000000	0.000000	1,783,485	54.00
54.01	05401	ULTRASOUND	0	4,682,721	0.000000	0.000000	759,397	54.01
56.00	05600	RADIOISOTOPE	0	18,402,951	0.000000	0.000000	3,321,590	56.00
57.00	05700	CT SCAN	0	30,913,525	0.000000	0.000000	4,485,425	57.00
58.00	05800	MRI	0	6,314,396	0.000000	0.000000	536,724	58.00
60.00	06000	LABORATORY	0	76,877,928	0.000000	0.000000	16,735,604	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,953,290	0.000000	0.000000	1,543,624	62.00
65.00	06500	RESPIRATORY THERAPY	0	11,921,667	0.000000	0.000000	5,309,630	65.00
66.00	06600	PHYSICAL THERAPY	0	8,454,178	0.000000	0.000000	2,609,548	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,810,912	0.000000	0.000000	817,284	67.00
68.00	06800	SPEECH PATHOLOGY	0	798,003	0.000000	0.000000	58,560	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69,806,632	0.000000	0.000000	20,995,470	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	12,983,680	0.000000	0.000000	4,788,832	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	34,006,355	0.000000	0.000000	11,488,321	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	46,938,532	0.000000	0.000000	10,045,448	73.00
74.00	07400	RENAL DIALYSIS	0	1,639,761	0.000000	0.000000	954,503	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	1,547,800	0.000000	0.000000	8,000	76.01
76.03	03951	WOUND CARE	0	1,386,550	0.000000	0.000000	7,023	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	50,464,318	0.000000	0.000000	5,898,810	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,551,354	0.000000	0.000000	687,607	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	510,423,425			109,473,794	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	11,796,954	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	1,393,458	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,302,435	0		54.00
54.01	05401	ULTRASOUND	0	1,086,144	0		54.01
56.00	05600	RADIOISOTOPE	0	3,319,380	0		56.00
57.00	05700	CT SCAN	0	5,980,612	0		57.00
58.00	05800	MRI	0	1,557,499	0		58.00
60.00	06000	LABORATORY	0	6,740,319	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,209,480	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	860,112	0		65.00
66.00	06600	PHYSICAL THERAPY	0	1,424	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	534	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,820,719	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	902,573	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,685,066	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,060,571	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	0	529,250	0		76.01
76.03	03951	WOUND CARE	0	525,968	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	7,010,447	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,265,364	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00		Total (lines 50-199)	0	73,048,309	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part V Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.090791	11,796,954	0	0	1,071,057	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.562046	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.022183	1,393,458	0	0	30,911	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337770	3,302,435	0	0	1,115,463	54.00
54.01	05401	ULTRASOUND	0.108223	1,086,144	0	0	117,546	54.01
56.00	05600	RADIOISOTOPE	0.044047	3,319,380	0	0	146,209	56.00
57.00	05700	CT SCAN	0.022284	5,980,612	0	0	133,272	57.00
58.00	05800	MRI	0.043500	1,557,499	0	0	67,751	58.00
60.00	06000	LABORATORY	0.054036	6,740,319	0	0	364,220	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.219655	1,209,480	0	0	265,668	62.00
65.00	06500	RESPIRATORY THERAPY	0.098554	860,112	0	0	84,767	65.00
66.00	06600	PHYSICAL THERAPY	0.199402	1,424	0	0	284	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.134796	534	0	0	72	67.00
68.00	06800	SPEECH PATHOLOGY	0.163041	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.055800	11,820,719	0	0	659,596	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.159012	902,573	0	0	143,520	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.201311	3,685,066	0	0	741,844	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142715	10,060,571	0	33,956	1,435,794	73.00
74.00	07400	RENAL DIALYSIS	0.205295	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.147602	529,250	0	0	78,118	76.01
76.03	03951	WOUND CARE	0.525932	525,968	0	0	276,623	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.094545	7,010,447	0	0	662,803	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284604	1,265,364	0	0	360,128	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		73,048,309	0	33,956	7,755,646	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		73,048,309	0	33,956	7,755,646	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part V Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,846		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	4,846		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	4,846		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,315	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,315	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)	12,299	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,444	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)	11,218,709	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)	11,218,709	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)	11,218,709	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)	783.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,266,463	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	4,266,463	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/25/2015 7:15 am

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	3,961,801	1,886	2,100.64	1,048	2,201,471	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	11,327,056	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	17,794,990	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)	1,140,264	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	832,174	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,972,438	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	15,822,552	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)	2,016	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	783.70	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,579,939	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,024,375	11,218,709	0.180446	1,579,939	285,094	90.00
91.00	Nursing School cost	0	11,218,709	0.000000	1,579,939	0	91.00
92.00	Allied health cost	0	11,218,709	0.000000	1,579,939	0	92.00
93.00	All other Medical Education	0	11,218,709	0.000000	1,579,939	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-3 | Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		16,498,670		30.00
31.00	03100	INTENSIVE CARE UNIT		4,567,606		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.090791	13,908,936	1,262,806	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.562046	16,920	9,510	52.00
53.00	05300	ANESTHESIOLOGY	0.022183	2,713,053	60,184	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337770	1,783,485	602,408	54.00
54.01	05401	ULTRASOUND	0.108223	759,397	82,184	54.01
56.00	05600	RADIOISOTOPE	0.044047	3,321,590	146,306	56.00
57.00	05700	CT SCAN	0.022284	4,485,425	99,953	57.00
58.00	05800	MRI	0.043500	536,724	23,347	58.00
60.00	06000	LABORATORY	0.054036	16,735,604	904,325	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.219655	1,543,624	339,065	62.00
65.00	06500	RESPIRATORY THERAPY	0.098554	5,309,630	523,285	65.00
66.00	06600	PHYSICAL THERAPY	0.199402	2,609,548	520,349	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.134796	817,284	110,167	67.00
68.00	06800	SPEECH PATHOLOGY	0.163041	58,560	9,548	68.00
69.00	06900	ELECTROCARDIOLOGY	0.055800	20,995,470	1,171,547	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.159012	4,788,832	761,482	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.201311	11,488,321	2,312,725	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142715	10,045,448	1,433,636	73.00
74.00	07400	RENAL DIALYSIS	0.205295	954,503	195,955	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.147602	8,000	1,181	76.01
76.03	03951	WOUND CARE	0.525932	7,023	3,694	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.094545	5,898,810	557,703	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284604	687,607	195,696	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		109,473,794	11,327,056	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)		109,473,794		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part A Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

			MDH	Non MDH	On or After Geo Reclassification		
		0	1.00	1.01	1.02	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS						
1.00	DRG Amounts Other than Outlier Payments		0	0	0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		5,049,077	0	0		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		0	6,909,354	0		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	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	0		1.04
2.00	Outlier payments for discharges. (see instructions)		253,326	0	0		2.00
2.01	Outlier reconciliation amount		0	0	0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	0	0		2.02
3.00	Managed Care Simulated Payments		1,050,077	0	0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		92.48				4.00
	Indirect Medical Education Adjustment						
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00				5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00				6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00				7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00				7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00				8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00				8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00				9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00				10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00				11.00
12.00	Current year allowable FTE (see instructions)		0.00				12.00
13.00	Total allowable FTE count for the prior year.		0.00				13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00				14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00				15.00
16.00	Adjustment for residents in initial years of the program		0.00				16.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part A Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

			MDH	Non MDH	On or After Geo Reclassification		
		0	1.00	1.01	1.02	2.00	
17.00	Adjusment for residents displaced by program or hospital closure		0.00				17.00
18.00	Adjusted rolling average FTE count		0.00				18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000				19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000				20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000				21.00
22.00	IME payment adjustment (see instructions)		0	0	0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	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).		0.00				23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00				24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00				25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000				26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000				27.00
28.00	IME add-on adjustment amount (see instructions)		0	0	0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	0	0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	0	0		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	0	0		29.01
	Disproportionate Share Adjustment						
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		6.03				30.00
31.00	Percentage of Medicaid patient days (see instructions)		32.41				31.00
32.00	Sum of lines 30 and 31		38.44				32.00
33.00	Allowable disproportionate share percentage (see instructions)		20.93	12.00	0.00		33.00
34.00	Disproportionate share adjustment (see instructions)		264,193	207,281	0		34.00

			Prior to October 1			
		0	1.00	1.01	1.02	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		9,046,380,143			35.00
35.01	Factor 3 (see instructions)		0.000151634			35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,371,742			35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		575,004			35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,269,147			36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	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 an 685. (see instructions)		0			43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part A Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

			Prior to October 1			
		0	1.00	1.01	1.02	
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	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)		6,141,600	7,810,778	0	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		5,823,779	0	0	48.00
49.00	Total payment for inpatient operating costs (see instructions)		13,952,378			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		992,806			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		14,945,184			59.00
60.00	Primary payer payments		0			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		14,945,184			61.00
62.00	Deductibles billed to program beneficiaries		1,487,332			62.00
63.00	Coinsurance billed to program beneficiaries		29,642			63.00
64.00	Allowable bad debts (see instructions)		182,285			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		118,485			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		128,436			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		13,546,695			67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0			68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0			69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0			70.00
70.50	RURAL DEMONSTRATION PROJECT		0			70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0			70.91
70.92	Bundled Model 1 discount amount (see instructions)		0			70.92
70.93	HVBP payment adjustment amount (see instructions)		-9,181			70.93
70.94	HRR adjustment amount (see instructions)		-112,170			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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part A Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

			Prior to October 1			
		0	1.00	1.01	1.02	
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)		13,425,344			71.00
71.01	Sequestration adjustment (see instructions)		268,507			71.01
72.00	Interim payments		13,525,854			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)		-369,017			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		857,794			75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0			90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00			94.00
95.00	Time value of money for operating expenses (see instructions)		0			95.00
96.00	Time value of money for capital related expenses (see instructions)		0			96.00

		Prior to 10/1			On/After 10/1	
		1.00	1.01	1.02	2.00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)	0			0	100.00
	HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	1.00008			0.998612	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0			0	102.00
	HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.9927			0.9891	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0			0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part A Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		On/After October 1		
		2.00		
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	7,647,644,885		35.00
35.01	Factor 3 (see instructions)	0.000156271		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,195,105		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	694,143		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)			36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)			41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)			41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)			45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)			46.00
47.00	Subtotal (see instructions)			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)			48.00
49.00	Total payment for inpatient operating costs (see instructions)			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			52.00
53.00	Nursing and Allied Health Managed Care payment			53.00
54.00	Special add-on payments for new technologies			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			58.00
59.00	Total (sum of amounts on lines 49 through 58)			59.00
60.00	Primary payer payments			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			61.00
62.00	Deductibles billed to program beneficiaries			62.00
63.00	Coinsurance billed to program beneficiaries			63.00
64.00	Allowable bad debts (see instructions)			64.00
65.00	Adjusted reimbursable bad debts (see instructions)			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			68.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part A Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		On/After October 1	
		2.00	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		70.00
70.50	RURAL DEMONSTRATION PROJECT		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		70.91
70.92	Bundled Model 1 discount amount (see instructions)		70.92
70.93	HVBP payment adjustment amount (see instructions)		70.93
70.94	HRR adjustment amount (see instructions)		70.94
70.95	Recovery of accelerated depreciation		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)		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)		70.97
70.98	Low Volume Payment-3		70.98
70.99	HAC adjustment amount (see instructions)		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		71.00
71.01	Sequestration adjustment (see instructions)		71.01
72.00	Interim payments		72.00
73.00	Tentative settlement (for contractor use only)		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		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)		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		93.00
94.00	The rate used to calculate the time value of money (see instructions)		94.00
95.00	Time value of money for operating expenses (see instructions)		95.00
96.00	Time value of money for capital related expenses (see instructions)		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140184	Period: From 05/01/2014 To 04/30/2015	Worksheet E Part B Date/Time Prepared: 9/25/2015 7:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,846	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,755,646	2.00
3.00	PPS payments	6,247,459	3.00
4.00	Outlier payment (see instructions)	122,417	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,846	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	33,956	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)	33,956	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	33,956	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	29,110	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)	4,846	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)	6,369,876	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,332,628	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)	5,042,094	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	5,042,094	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	5,042,094	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)	180,823	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	117,535	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	146,254	36.00
37.00	Subtotal (see instructions)	5,159,629	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)	5,159,629	40.00
40.01	Sequestration adjustment (see instructions)	103,193	40.01
41.00	Interim payments	5,121,198	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-64,762	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E-1 Part I Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		13,525,854		5,121,198	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		13,525,854		5,121,198	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		369,017		64,762	6.02
7.00	Total Medicare program liability (see instructions)		13,156,837		5,056,436	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140184 | Component CCN: 14U184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 9/25/2015 7:15 am

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140184	Period: From 05/01/2014 To 04/30/2015	Worksheet E-1 Part II Date/Time Prepared: 9/25/2015 7:15 am
	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	4,803	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	6,492	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	604	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	14,185	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	556,003,673	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	394,079	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1,025,279	8.00
9.00	Sequestration adjustment amount (see instructions)	20,506	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,004,773	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1,166,657	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)	-161,884	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 140184 Component CCN: 14U184	Period: From 05/01/2014 To 04/30/2015	Worksheet E-2 Date/Time Prepared: 9/25/2015 7:15 am
	Title XVIII	Swing Beds - SNF	PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
20.00	Interim payments	0	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet G | Date/Time Prepared: 9/25/2015 7:15 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-1,192,796	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	19,405,304	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,890,913	0	0	0	6.00
7.00	Inventory	2,947,846	0	0	0	7.00
8.00	Prepaid expenses	1,158,747	0	0	0	8.00
9.00	Other current assets	-76,597	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)	19,351,591	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,393,860	0	0	0	12.00
13.00	Land improvements	562,648	0	0	0	13.00
14.00	Accumulated depreciation	-360,876	0	0	0	14.00
15.00	Buildings	46,974,794	0	0	0	15.00
16.00	Accumulated depreciation	-10,930,708	0	0	0	16.00
17.00	Leasehold improvements	3,828,658	0	0	0	17.00
18.00	Accumulated depreciation	-1,794,940	0	0	0	18.00
19.00	Fixed equipment	2,278,523	0	0	0	19.00
20.00	Accumulated depreciation	-1,438,030	0	0	0	20.00
21.00	Automobiles and trucks	2,994	0	0	0	21.00
22.00	Accumulated depreciation	-2,994	0	0	0	22.00
23.00	Major movable equipment	18,628,685	0	0	0	23.00
24.00	Accumulated depreciation	-11,315,135	0	0	0	24.00
25.00	Minor equipment depreciable	5,829,209	0	0	0	25.00
26.00	Accumulated depreciation	-4,024,899	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	49,631,789	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	4,915,313	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,915,313	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	73,898,693	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,058,649	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,771,167	0	0	0	38.00
39.00	Payroll taxes payable	-319	0	0	0	39.00
40.00	Notes and loans payable (short term)	15,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-282,160,328	0	0	0	43.00
44.00	Other current liabilities	1,643,335	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-274,672,496	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	33,750	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	33,750	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	-274,638,746	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	348,537,439				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	348,537,439	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	73,898,693	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet G-1 | Date/Time Prepared: 9/25/2015 7:15 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		304,071,926		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		44,465,514				2.00
3.00	Total (sum of line 1 and line 2)		348,537,440		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		348,537,440		0		11.00
12.00	ROUNDING	1		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		348,537,439		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	ROUNDING		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140184 | Period: From 05/01/2014 To 04/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/25/2015 7:15 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	37,352,444		37,352,444	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)	37,352,444		37,352,444	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	8,227,804		8,227,804	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	8,227,804		8,227,804	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	45,580,248		45,580,248	17.00
18.00	Ancillary services	220,162,970	234,244,783	454,407,753	18.00
19.00	Outpatient services	13,358,223	42,657,449	56,015,672	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CRNA CHARGES	1,741,287	1,654,836	3,396,123	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	280,842,728	278,557,068	559,399,796	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		78,413,164		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)		78,413,164		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140184	Period: From 05/01/2014 To 04/30/2015	Worksheet G-3 Date/Time Prepared: 9/25/2015 7:15 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	559,399,796	1.00
2.00	Less contractual allowances and discounts on patients' accounts	438,127,936	2.00
3.00	Net patient revenues (line 1 minus line 2)	121,271,860	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	78,413,164	4.00
5.00	Net income from service to patients (line 3 minus line 4)	42,858,696	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,606,818	24.00
25.00	Total other income (sum of lines 6-24)	1,606,818	25.00
26.00	Total (line 5 plus line 25)	44,465,514	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	44,465,514	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140184	Period: From 05/01/2014 To 04/30/2015	Worksheet L Parts I-III Date/Time Prepared: 9/25/2015 7:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	941,994	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	50,812	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)	38.86	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	992,806	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