

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: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/26/2016 4:43 pm
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/26/2016 Time: 4:43 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SOUTH SUBURBAN HOSPITAL ( 140250 ) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_ Title

\_\_\_\_\_ Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	702,404	187,373	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	29,400	0	0	0	7.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
200.00 Total	0	731,804	187,373	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140250			Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 3:21 pm		
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL		4.00 Zip Code: 60429- County: COOK			
Street: 178TH STREET AND KEDZIE AVE		City: HAZELCREST							
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
V		XVIII		XIX					
Hospital and Hospital-Based Component Identification:									
3.00	Hospital	SOUTH SUBURBAN HOSPITAL	140250	16974	1	07/01/1966	N	P	0
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF	SOUTH SUBURBAN NURSING UNIT	145599	16974		05/01/1988	N	P	0
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
17.10	Hospital-Based (CORF) I								
18.00	Renal Dialysis								
19.00	Other								
						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2015	12/31/2015		20.00
21.00	Type of Control (see instructions)					2			21.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						1	N	23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,795	595	0	0	7,847	0		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	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 3:21 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y				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: 140250

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/26/2016 3:21 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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
<b>Teaching Hospitals that Claim Residents in Nonprovider Settings</b>						
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
<b>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.</b>						
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: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 3:21 pm		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
				1.00	2.00	3.00
<b>Long Term Care Hospital PPS</b>						
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
<b>TEFRA Providers</b>						
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.			N		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N		87.00
				V	XIX	
				1.00	2.00	
<b>Title V and XIX Services</b>						
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	N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V		XIX			
		1.00		2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N			96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		97.00
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N					105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N					106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N					108.00
		Physical		Speech		Respiratory	
		1.00		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	
						1.00	
						2.00	
						3.00	
<b>Miscellaneous Cost Reporting Information</b>							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	4,976,468		18,861,383		0	
						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			
119.00	DO NOT USE THIS LINE						
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	
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			
<b>Transplant Center Information</b>							
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			
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.						
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.						
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.						
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.						
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.						
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.						
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.						
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.						
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.						

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 3:21 pm			
		1.00	2.00				
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	148036	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: ADVOCATE HEALTHCARE	Contractor's Name: NATIONAL GOVT SERV		Contractor's Number: 00131			
142.00	Street: 3075 HIGHLAND PARKWAY	PO Box:					
143.00	City: DOWNERS GROVE	State: IL	Zip Code: 60515				
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?	Y		144.00			
				1.00 2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00			
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00			
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00			
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00			
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
				1.00			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00			
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y		167.00			
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0		168.00			
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01			
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99		169.00			
				1.00			
				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)	01/01/2015		12/31/2015		170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 3:21 pm
			1.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N 171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/26/2016 3:21 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	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)	Y	05/12/2016	Y	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: 140250

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/26/2016 3:21 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
				1.00	2.00
<b>Cost Report Preparer Contact Information</b>					
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.	MI CHAEL		VOLANTE	41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVOCATE HEALTH CARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-929-5771		MI CHAEL.VOLANTE@ADVOCATEHEALTH.COM	43.00

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	05/12/2016	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	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF REIMBURSEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140250

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/26/2016 3:21 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	223	81,395	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)		223	81,395	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	20	7,300	0.00	0	8.00
9.00 CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		243	88,695	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	41	14,965		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		284				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: 140250

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/26/2016 3:21 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	13,358	1,931	34,911			1.00
2.00 HMO and other (see instructions)	7,206	7,847				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)	13,358	1,931	34,911			7.00
8.00 INTENSIVE CARE UNIT	2,390	389	5,643			8.00
9.00 CORONARY CARE UNIT	0	0	0			9.00
10.00 BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00 SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		751	3,008			13.00
14.00 Total (see instructions)	15,748	3,071	43,562	0.00	1,032.76	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY	5,873	0	10,097	0.00	40.46	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	1,304			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	1,073.22	27.00
28.00 Observation Bed Days		863	10,380			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	319	413			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: 140250

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/26/2016 3:21 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	3,407	808	10,260	1.00
2.00 HMO and other (see instructions)				1,604	2,575		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		3,407	808	10,260	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF	0.00	0		0	0	0	17.00
18.00 SUBPROVIDER	0.00	0		0	0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00						19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
25.10 CMHC - CORF	0.00						25.10
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						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: 140250

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/26/2016 3:21 pm

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	70,812,285	0	70,812,285	2,240,147.00	31.61
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		612,541	0	612,541	1,732.00	353.66
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		200,268	0	200,268	1.00	200,268.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	2,368,968	39,531	2,408,499	84,387.00	28.54
10.00	Excluded area salaries (see instructions)		85,486	117,552	203,038	4,689.00	43.30
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor: Direct Patient Care		4,745,217	0	4,745,217	73,192.00	64.83
12.00	Contract labor: Top level management and other management and administrative services		776,767	0	776,767	4,683.00	165.87
13.00	Contract labor: Physician-Part A - Administrative		328,319	0	328,319	1,878.00	174.82
14.00	Home office salaries & wage-related costs		7,007,153	0	7,007,153	112,005.00	62.56
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		18,605,952	0	18,605,952		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		703,537	0	703,537		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	1,635,559	-1,140,187	495,372	10,720.00	46.21
27.00	Administrative & General	5.00	6,443,602	-390,702	6,052,900	156,740.00	38.62
28.00	Administrative & General under contract (see inst.)		776,767	0	776,767	4,683.00	165.87
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	2,013,997	35,712	2,049,709	75,335.00	27.21
31.00	Laundry & Linen Service	8.00	133,848	1,400	135,248	8,718.00	15.51
32.00	Housekeeping	9.00	1,473,578	14,191	1,487,769	106,871.00	13.92
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	1,775,421	-802,230	973,191	108,915.00	8.94
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	826,576	826,576	50,707.00	16.30
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	4,077,654	105,066	4,182,720	87,453.00	47.83
39.00	Central Services and Supply	14.00	385,957	62,305	448,262	19,334.00	23.19
40.00	Pharmacy	15.00	2,670,905	42,795	2,713,700	59,964.00	45.26

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140250

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/26/2016 3:21 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
41.00	Medical Records & Medical Records Library	16.00	1,243,666	0	1,243,666	54,082.00	23.00	41.00
42.00	Social Service	17.00	820,717	3,771	824,488	21,900.00	37.65	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140250

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/26/2016 3:21 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	71,388,784	0	71,388,784	2,244,829.00	31.80	1.00
2.00	Excluded area salaries (see instructions)	2,454,454	157,083	2,611,537	89,076.00	29.32	2.00
3.00	Subtotal salaries (line 1 minus line 2)	68,934,330	-157,083	68,777,247	2,155,753.00	31.90	3.00
4.00	Subtotal other wages & related costs (see inst.)	12,857,456	0	12,857,456	191,758.00	67.05	4.00
5.00	Subtotal wage-related costs (see inst.)	18,605,952	0	18,605,952	0.00	27.05	5.00
6.00	Total (sum of lines 3 thru 5)	100,397,738	-157,083	100,240,655	2,347,511.00	42.70	6.00
7.00	Total overhead cost (see instructions)	23,451,671	-1,241,303	22,210,368	765,422.00	29.02	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part IV Date/Time Prepared: 5/26/2016 3:21 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			1,422,348 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)			1,361,712 4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			146,230 6.00
7.00	Employee Managed Care Program Administration Fees			801,198 7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)			5,090,198 8.00
9.00	Prescription Drug Plan			1,715,865 9.00
10.00	Dental, Hearing and Vision Plan			176,059 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			89,200 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			457,183 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			2,274,552 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
<b>TAXES</b>				
17.00	FICA-Employers Portion Only			5,069,372 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			180,171 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			179,601 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			345,800 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			19,309,489 24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER EMPLOYEE COSTS			143,807 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140250

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	4,190,597	19,309,489	1.00
2.00	Hospital	4,190,597	18,605,952	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	656,331	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	47,206	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140250

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

Worksheet S-7

Date/Time Prepared:  
5/26/2016 3:21 pm

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N			2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	3.00
4.00		RUL	57	0	4.00
5.00		RVX	8	0	5.00
6.00		RVL	55	0	6.00
7.00		RHX	0	0	7.00
8.00		RHL	7	0	8.00
9.00		RMX	0	0	9.00
10.00		RML	0	0	10.00
11.00		RLX	0	0	11.00
12.00		RUC	226	0	12.00
13.00		RUB	1,538	0	13.00
14.00		RUA	890	0	14.00
15.00		RVC	550	0	15.00
16.00		RVB	1,369	0	16.00
17.00		RVA	610	0	17.00
18.00		RHC	55	0	18.00
19.00		RHB	84	0	19.00
20.00		RHA	145	0	20.00
21.00		RMC	16	0	21.00
22.00		RMB	18	0	22.00
23.00		RMA	64	0	23.00
24.00		RLB	0	0	24.00
25.00		RLA	3	0	25.00
26.00		ES3	0	0	26.00
27.00		ES2	0	0	27.00
28.00		ES1	2	0	28.00
29.00		HE2	0	0	29.00
30.00		HE1	2	0	30.00
31.00		HD2	0	0	31.00
32.00		HD1	0	0	32.00
33.00		HC2	0	0	33.00
34.00		HC1	5	0	34.00
35.00		HB2	0	0	35.00
36.00		HB1	35	0	36.00
37.00		LE2	0	0	37.00
38.00		LE1	0	0	38.00
39.00		LD2	0	0	39.00
40.00		LD1	0	0	40.00
41.00		LC2	0	0	41.00
42.00		LC1	19	0	42.00
43.00		LB2	0	0	43.00
44.00		LB1	5	0	44.00
45.00		CE2	0	0	45.00
46.00		CE1	0	0	46.00
47.00		CD2	0	0	47.00
48.00		CD1	5	0	48.00
49.00		CC2	0	0	49.00
50.00		CC1	25	0	50.00
51.00		CB2	0	0	51.00
52.00		CB1	22	0	52.00
53.00		CA2	0	0	53.00
54.00		CA1	27	0	54.00
55.00		SE3	0	0	55.00
56.00		SE2	0	0	56.00
57.00		SE1	0	0	57.00
58.00		SSC	0	0	58.00
59.00		SSB	0	0	59.00
60.00		SSA	0	0	60.00
61.00		IB2	0	0	61.00
62.00		IB1	0	0	62.00
63.00		IA2	0	0	63.00
64.00		IA1	0	0	64.00
65.00		BB2	0	0	65.00
66.00		BB1	0	0	66.00
67.00		BA2	0	0	67.00
68.00		BA1	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140250

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

Worksheet S-7

Date/Time Prepared:  
5/26/2016 3:21 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	5	0	5	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	25	0	25	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	1	0	1	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		5,873	0	5,873	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).		16974	16974	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		2,368,968	27.26	Y	202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		8,689,842			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 5/26/2016 3:21 pm
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				1.00	
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.215702		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		22,911,666		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		187,314,076		6.00
7.00	Medicaid cost (line 1 times line 6)		40,404,021		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)		17,492,355		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		17,492,355		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	9,675,452	2,191,900	11,867,352	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,087,014	472,797	2,559,811	21.00
22.00	Partial payment by patients approved for charity care	123,091	126,330	249,421	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,963,923	346,467	2,310,390	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)		12,975,357		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		1,064,695		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		11,910,662		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,569,154		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,879,544		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		22,371,899		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140250

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

Worksheet A  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		4,595,885	4,595,885	4,318,162	8,914,047
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,635,559	14,436,705	16,072,264	-1,140,255	14,932,009
5.00	00500	ADMINISTRATIVE & GENERAL	6,443,602	46,789,819	53,233,421	-970,229	52,263,192
7.00	00700	OPERATION OF PLANT	2,013,997	4,455,886	6,469,883	-86,081	6,383,802
8.00	00800	LAUNDRY & LINEN SERVICE	133,848	17,137	150,985	-2,331	148,654
9.00	00900	HOUSEKEEPING	1,473,578	1,164,804	2,638,382	-11,442	2,626,940
10.00	01000	DIETARY	1,775,421	1,134,105	2,909,526	-1,559,840	1,349,686
11.00	01100	CAFETERIA	0	0	0	1,548,013	1,548,013
13.00	01300	NURSING ADMINISTRATION	4,077,654	525,746	4,603,400	98,538	4,701,938
14.00	01400	CENTRAL SERVICES & SUPPLY	385,957	438,645	824,602	-65,074	759,528
15.00	01500	PHARMACY	2,670,905	11,255,479	13,926,384	-12,338,959	1,587,425
16.00	01600	MEDICAL RECORDS & LIBRARY	1,243,666	796,376	2,040,042	-1,428	2,038,614
17.00	01700	SOCIAL SERVICE	820,717	93,140	913,857	3,734	917,591
23.00	02301	PARAMEDICAL ED PRGM	85,486	40,442	125,928	85,680	211,608
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	19,227,535	7,688,509	26,916,044	-2,516,681	24,399,363
31.00	03100	INTENSIVE CARE UNIT	3,674,745	1,798,013	5,472,758	-526,604	4,946,154
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	521,982	655,102	1,177,084	-90,767	1,086,317
44.00	04400	SKILLED NURSING FACILITY	2,368,968	443,502	2,812,470	-100,370	2,712,100
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	4,157,363	13,808,349	17,965,712	-11,138,516	6,827,196
53.00	05300	ANESTHESIOLOGY	95,876	437,944	533,820	611,509	1,145,329
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,410,726	2,328,150	6,738,876	-1,572,479	5,166,397
56.00	05600	RADIO SOTOPE	279,424	604,118	883,542	-18,086	865,456
56.01	05601	ULTRASOUND	666,546	172,772	839,318	-96,015	743,303
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	1,211,783	4,989,444	6,201,227	-4,665,984	1,535,243
60.00	06000	LABORATORY	0	7,054,543	7,054,543	-2,427	7,052,116
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,423,030	1,423,030	-919,356	503,674
64.00	06400	INTRAVENOUS THERAPY	342,570	204,658	547,228	-140,229	406,999
65.00	06500	RESPIRATORY THERAPY	1,458,540	421,213	1,879,753	-174,736	1,705,017
66.00	06600	PHYSICAL THERAPY	95,671	4,408,084	4,503,755	-1,413,284	3,090,471
67.00	06700	OCCUPATIONAL THERAPY	0	338	338	1,381,208	1,381,546
68.00	06800	SPEECH PATHOLOGY	231,643	23,989	255,632	-919	254,713
69.00	06900	ELECTROCARDIOLOGY	864,096	258,743	1,122,839	78,855	1,201,694
70.00	07000	ELECTROENCEPHALOGRAPHY	82,756	36,806	119,562	-29,708	89,854
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,951,865	12,951,865
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	7,837,666	7,837,666
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,229,626	12,229,626
74.00	07400	RENAL DIALYSIS	410,048	183,086	593,134	-111,152	481,982
75.00	07500	ASC (NON-DISTINCT PART)	1,394,946	491,576	1,886,522	-87,656	1,798,866
76.00	03560	PULMONARY FUNCTION TESTING	70,036	6,553	76,589	26,739	103,328
76.97	07697	CARDIAC REHABILITATION	292,888	45,299	338,187	38,146	376,333
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	1,567,095	934,457	2,501,552	-658,906	1,842,646
91.00	09100	EMERGENCY	4,323,843	3,423,385	7,747,228	-776,876	6,970,352
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04950	SLEEP LAB	302,815	191,277	494,092	-23,343	470,749
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	1,546,653	1,546,653	0	1,546,653
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	30,000	30,000
118.00		SUBTOTALS (SUM OF LINES 1-117)	70,812,285	139,323,762	210,136,047	8	210,136,055

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140250

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

Worksheet A  
Date/Time Prepared:  
5/26/2016 3:21 pm

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		
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54,380	54,380	0	54,380	190.00
190.01	19001	NONREIMBURSABLE HHA	0	6,601	6,601	-8	6,593	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	70,812,285	139,384,743	210,197,028	0	210,197,028	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140250

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

Worksheet A  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,712,345	10,626,392	1.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,656,998	17,589,007	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-18,136,634	34,126,558	5.00
7.00	00700	OPERATION OF PLANT	-67,905	6,315,897	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	148,654	8.00
9.00	00900	HOUSEKEEPING	-366	2,626,574	9.00
10.00	01000	DIETARY	0	1,349,686	10.00
11.00	01100	CAFETERIA	-599,915	948,098	11.00
13.00	01300	NURSING ADMINISTRATION	-1,102	4,700,836	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	759,528	14.00
15.00	01500	PHARMACY	-100	1,587,325	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,862	2,035,752	16.00
17.00	01700	SOCIAL SERVICE	-26,624	890,967	17.00
23.00	02301	PARAMEDICAL ED PRGM	-12,201	199,407	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-2,813,278	21,586,085	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,946,154	31.00
32.00	03200	CORONARY CARE UNIT	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	-495,000	591,317	43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,712,100	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-405	6,826,791	50.00
53.00	05300	ANESTHESIOLOGY	-897,682	247,647	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-62,519	5,103,878	54.00
56.00	05600	RADIOISOTOPE	-7,738	857,718	56.00
56.01	05601	ULTRASOUND	-160	743,143	56.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,535,243	59.00
60.00	06000	LABORATORY	-362,670	6,689,446	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	503,674	62.00
64.00	06400	INTRAVENOUS THERAPY	0	406,999	64.00
65.00	06500	RESPIRATORY THERAPY	-280	1,704,737	65.00
66.00	06600	PHYSICAL THERAPY	-150	3,090,321	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,381,546	67.00
68.00	06800	SPEECH PATHOLOGY	0	254,713	68.00
69.00	06900	ELECTROCARDIOLOGY	-2,814	1,198,880	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	89,854	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,951,865	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	7,837,666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,229,626	73.00
74.00	07400	RENAL DIALYSIS	0	481,982	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	1,798,866	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0	103,328	76.00
76.97	07697	CARDIAC REHABILITATION	0	376,333	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-90,896	1,751,750	90.00
91.00	09100	EMERGENCY	-1,588,393	5,381,959	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04950	SLEEP LAB	0	470,749	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	CORF	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	112.00
113.00	11300	INTEREST EXPENSE	-1,546,653	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	-30,000	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-22,377,004	187,759,051	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54,380	190.00
190.01	19001	NONREIMBURSABLE HHA	-6,601	-8	190.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140250

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

Worksheet A  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6.00	7.00	
194.00	07950	FUND RAISING	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	-22,383,605	187,813,423	194.00
					200.00

RECLASSIFICATIONS

Provider CCN: 140250

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

Worksheet A-6  
Date/Time Prepared:  
5/26/2016 3:21 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>A - CAFETERIA COSTS</b>						
1.00	CAFETERIA	11.00	826,576	721,437	1.00	
	TOTALS		826,576	721,437		
<b>B - PATIENT DRUGS</b>						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	12,229,626	1.00	
	TOTALS		0	12,229,626		
<b>C - PHYSICIAN COMPENSATION</b>						
1.00	UTILIZATION REVIEW-SNF	114.00	30,000	0	1.00	
	TOTALS		30,000	0		
<b>D - CENTRAL PROCESSING</b>						
1.00	CENTRAL SERVICES & SUPPLY	14.00	51,837	0	1.00	
	TOTALS		51,837	0		
<b>E - MEDICAL DIRECTORS - PHYSICIANS</b>						
1.00	ADULTS & PEDIATRICS	30.00	48,278	25,000	1.00	
2.00	SKILLED NURSING FACILITY	44.00	14,850	9,900	2.00	
3.00	OPERATING ROOM	50.00	204,147	93,100	3.00	
4.00	ANESTHESIOLOGY	53.00	0	919,682	4.00	
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	90,000	5.00	
6.00	RESPIRATORY THERAPY	65.00	81,120	0	6.00	
7.00	ELECTROCARDIOLOGY	69.00	38,000	0	7.00	
8.00	RENAL DIALYSIS	74.00	15,600	0	8.00	
9.00	PULMONARY FUNCTION TESTING	76.00	0	27,070	9.00	
10.00	CLINIC	90.00	10,000	47,600	10.00	
11.00	EMERGENCY	91.00	64,000	12,833	11.00	
	TOTALS		475,995	1,225,185		
<b>F - EDUCATION COST</b>						
1.00	PARAMEDICAL ED PRGM	23.00	87,202	0	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
	TOTALS		87,202	0		
<b>G - CONTRACTED OR NURSE ASSISTANTS</b>						
1.00	OPERATING ROOM	50.00	0	112,100	1.00	
	TOTALS		0	112,100		
<b>H - EQUIP DEPR</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	4,318,162	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
32.00		0.00	0	0	32.00	
33.00		0.00	0	0	33.00	
34.00		0.00	0	0	34.00	
35.00		0.00	0	0	35.00	
36.00		0.00	0	0	36.00	
37.00		0.00	0	0	37.00	
38.00		0.00	0	0	38.00	

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
39.00		0.00	0	0	39.00
	TOTALS		0	4,318,162	
I - OCCUPATIONAL THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	0	1,381,476	1.00
	TOTALS		0	1,381,476	
J - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	20,789,531	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
	TOTALS		0	20,789,531	
K - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	7,837,666	1.00
	TOTALS		0	7,837,666	
L - CARDIOLOGY ADMINISTRATION					
1.00	CARDIAC CATHETERIZATION	59.00	183,309	36,091	1.00
2.00	ELECTROCARDIOLOGY	69.00	130,714	25,735	2.00
3.00	CARDIAC REHABILITATION	76.97	44,306	8,723	3.00
	TOTALS		358,329	70,549	
M - MANAGEMENT INCENTIVES					
1.00	ADMINISTRATIVE & GENERAL	5.00	513,480	0	1.00
2.00	OPERATION OF PLANT	7.00	24,865	0	2.00
3.00	DIETARY	10.00	8,019	0	3.00
4.00	NURSING ADMINISTRATION	13.00	94,103	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	8,019	0	5.00
6.00	PHARMACY	15.00	33,076	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	41,131	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	9,264	0	8.00
9.00	SKILLED NURSING FACILITY	44.00	9,795	0	9.00
10.00	OPERATING ROOM	50.00	9,264	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	32,680	0	11.00
12.00	RESPIRATORY THERAPY	65.00	8,019	0	12.00
13.00	ASC (NON-DIAGNOSTIC PART)	75.00	9,105	0	13.00
14.00	EMERGENCY	91.00	9,264	0	14.00
	TOTALS		810,084	0	

RECLASSIFICATIONS

Provider CCN: 140250

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

Worksheet A-6

Date/Time Prepared:  
5/26/2016 3:21 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	N - ASSOCIATE BONUSES				
1.00	ADMINISTRATIVE & GENERAL	5.00	24,726	0	1.00
2.00	OPERATION OF PLANT	7.00	10,847	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	1,400	0	3.00
4.00	HOUSEKEEPING	9.00	14,191	0	4.00
5.00	DIETARY	10.00	16,327	0	5.00
6.00	NURSING ADMINISTRATION	13.00	10,963	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	2,449	0	7.00
8.00	PHARMACY	15.00	9,719	0	8.00
9.00	SOCIAL SERVICE	17.00	3,771	0	9.00
10.00	PARAMEDICAL ED PRGM	23.00	350	0	10.00
11.00	ADULTS & PEDIATRICS	30.00	100,629	0	11.00
12.00	INTENSIVE CARE UNIT	31.00	13,101	0	12.00
13.00	NURSERY	43.00	1,865	0	13.00
14.00	SKILLED NURSING FACILITY	44.00	14,886	0	14.00
15.00	OPERATING ROOM	50.00	18,583	0	15.00
16.00	ANESTHESIOLOGY	53.00	661	0	16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	24,683	0	17.00
18.00	RADIOISOTOPE	56.00	1,205	0	18.00
19.00	ULTRASOUND	56.01	2,954	0	19.00
20.00	CARDIAC CATHETERIZATION	59.00	4,121	0	20.00
21.00	INTRAVENOUS THERAPY	64.00	1,283	0	21.00
22.00	RESPIRATORY THERAPY	65.00	6,803	0	22.00
23.00	PHYSICAL THERAPY	66.00	350	0	23.00
24.00	SPEECH PATHOLOGY	68.00	894	0	24.00
25.00	ELECTROCARDIOLOGY	69.00	5,597	0	25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	700	0	26.00
27.00	RENAL DIALYSIS	74.00	1,361	0	27.00
28.00	ASC (NON-DISTINCT PART)	75.00	6,335	0	28.00
29.00	PULMONARY FUNCTION TESTING	76.00	311	0	29.00
30.00	CARDIAC REHABILITATION	76.97	1,166	0	30.00
31.00	CLINIC	90.00	8,436	0	31.00
32.00	EMERGENCY	91.00	19,436	0	32.00
	TOTALS		330,103	0	
500.00	Grand Total: Increases		2,970,126	48,685,732	500.00

RECLASSIFICATIONS

Provider CCN: 140250

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

Worksheet A-6  
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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - CAFETERIA COSTS</b>							
1.00	DIETARY	10.00	826,576	721,437	0		1.00
	TOTALS		826,576	721,437			
<b>B - PATIENT DRUGS</b>							
1.00	PHARMACY	15.00	0	12,229,626	0		1.00
	TOTALS		0	12,229,626			
<b>C - PHYSICIAN COMPENSATION</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	30,000	0	0		1.00
	TOTALS		30,000	0			
<b>D - CENTRAL PROCESSING</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	51,837	0	0		1.00
	TOTALS		51,837	0			
<b>E - MEDICAL DIRECTORS - PHYSICIANS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	475,995	327,503	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	897,682	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
	TOTALS		475,995	1,225,185			
<b>F - EDUCATION COST</b>							
1.00	ADULTS & PEDIATRICS	30.00	16,064	0	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	13,217	0	0		2.00
3.00	EMERGENCY	91.00	45,174	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	12,747	0	0		4.00
	TOTALS		87,202	0			
<b>G - CONTRACTED OR NURSE ASSISTANTS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	112,100	0		1.00
	TOTALS		0	112,100			
<b>H - EQUIP DEPR</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,398	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	2,080	0		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	27,223	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	232	0		5.00
6.00	ADMINISTRATIVE & GENERAL	5.00	0	3,809	0		6.00
7.00	ADMINISTRATIVE & GENERAL	5.00	0	29,566	0		7.00
8.00	OPERATION OF PLANT	7.00	0	118,795	0		8.00
9.00	HOUSEKEEPING	9.00	0	17,782	0		9.00
10.00	DIETARY	10.00	0	31,868	0		10.00
11.00	NURSING ADMINISTRATION	13.00	0	5,358	0		11.00
12.00	CENTRAL SERVICES & SUPPLY	14.00	0	15,387	0		12.00
13.00	PHARMACY	15.00	0	131,409	0		13.00
14.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,428	0		14.00
15.00	PARAMEDICAL ED PRGM	23.00	0	1,790	0		15.00
16.00	ADULTS & PEDIATRICS	30.00	0	532,380	0		16.00
17.00	INTENSIVE CARE UNIT	31.00	0	99,351	0		17.00
18.00	NURSERY	43.00	0	40,689	0		18.00
19.00	SKILLED NURSING FACILITY	44.00	0	838	0		19.00
20.00	OPERATING ROOM	50.00	0	1,218,665	0		20.00
21.00	ANESTHESIOLOGY	53.00	0	66,550	0		21.00
22.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,089,820	0		22.00
23.00	RADIOISOTOPE	56.00	0	15,997	0		23.00
24.00	ULTRASOUND	56.01	0	54,435	0		24.00
25.00	CARDIAC CATHETERIZATION	59.00	0	314,143	0		25.00
26.00	LABORATORY	60.00	0	2,317	0		26.00
27.00	INTRAVENOUS THERAPY	64.00	0	9,219	0		27.00
28.00	RESPIRATORY THERAPY	65.00	0	16,048	0		28.00
29.00	PHYSICAL THERAPY	66.00	0	7,607	0		29.00
30.00	OCCUPATIONAL THERAPY	67.00	0	205	0		30.00
31.00	ELECTROCARDIOLOGY	69.00	0	106,272	0		31.00
32.00	ELECTROENCEPHALOGRAPHY	70.00	0	22,151	0		32.00
33.00	RENAL DIALYSIS	74.00	0	28,488	0		33.00
34.00	ASC (NON-DISTINCT PART)	75.00	0	55,444	0		34.00
35.00	PULMONARY FUNCTION TESTING	76.00	0	34	0		35.00
36.00	CARDIAC REHABILITATION	76.97	0	10,953	0		36.00
37.00	CLINIC	90.00	0	12,415	0		37.00
38.00	EMERGENCY	91.00	0	223,941	0		38.00
39.00	SLEEP LAB	93.00	0	2,037	0		39.00

RECLASSIFICATIONS

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		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	TOTALS		0	4,318,162		
<b>I - OCCUPATIONAL THERAPY</b>						
1.00	PHYSICAL THERAPY	66.00	0	1,381,476	0	1.00
	TOTALS		0	1,381,476		
<b>J - MEDICAL SUPPLIES</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	30	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	67	0	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	5,000	0	3.00
4.00	OPERATION OF PLANT	7.00	0	2,998	0	4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	3,731	0	5.00
6.00	HOUSEKEEPING	9.00	0	7,851	0	6.00
7.00	DIETARY	10.00	0	4,305	0	7.00
8.00	NURSING ADMINISTRATION	13.00	0	1,170	0	8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	111,992	0	9.00
10.00	PHARMACY	15.00	0	20,719	0	10.00
11.00	SOCIAL SERVICE	17.00	0	37	0	11.00
12.00	PARAMEDICAL ED PRGM	23.00	0	82	0	12.00
13.00	ADULTS & PEDIATRICS	30.00	0	1,285,593	0	13.00
14.00	INTENSIVE CARE UNIT	31.00	0	436,401	0	14.00
15.00	NURSERY	43.00	0	51,943	0	15.00
16.00	SKILLED NURSING FACILITY	44.00	0	148,963	0	16.00
17.00	OPERATING ROOM	50.00	0	10,357,045	0	17.00
18.00	ANESTHESIOLOGY	53.00	0	242,284	0	18.00
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	630,022	0	19.00
20.00	RADIOISOTOPE	56.00	0	3,294	0	20.00
21.00	ULTRASOUND	56.01	0	44,534	0	21.00
22.00	CARDIAC CATHETERIZATION	59.00	0	4,575,362	0	22.00
23.00	LABORATORY	60.00	0	110	0	23.00
24.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	919,356	0	24.00
25.00	INTRAVENOUS THERAPY	64.00	0	132,293	0	25.00
26.00	RESPIRATORY THERAPY	65.00	0	254,630	0	26.00
27.00	PHYSICAL THERAPY	66.00	0	24,551	0	27.00
28.00	OCCUPATIONAL THERAPY	67.00	0	63	0	28.00
29.00	SPEECH PATHOLOGY	68.00	0	1,813	0	29.00
30.00	ELECTROCARDIOLOGY	69.00	0	14,919	0	30.00
31.00	ELECTROENCEPHALOGRAPHY	70.00	0	8,257	0	31.00
32.00	RENAL DIALYSIS	74.00	0	99,625	0	32.00
33.00	ASC (NON-DISTINCT PART)	75.00	0	47,652	0	33.00
34.00	PULMONARY FUNCTION TESTING	76.00	0	608	0	34.00
35.00	CARDIAC REHABILITATION	76.97	0	5,096	0	35.00
36.00	CLINIC	90.00	0	712,527	0	36.00
37.00	EMERGENCY	91.00	0	613,294	0	37.00
38.00	SLEEP LAB	93.00	0	21,306	0	38.00
39.00	NONREIMBURSABLE HHA	190.01	0	8	0	39.00
	TOTALS		0	20,789,531		
<b>K - IMPLANTS</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,837,666	0	1.00
	TOTALS		0	7,837,666		
<b>L - RADIOLOGY ADMINISTRATION</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	358,329	70,549	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		358,329	70,549		
<b>M - MANAGEMENT INCENTIVES</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	810,084	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
	TOTALS		810,084	0		

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Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
N - ASSOCIATE BONUSES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	330,103	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
25.00		0.00	0	0	0	25.00
26.00		0.00	0	0	0	26.00
27.00		0.00	0	0	0	27.00
28.00		0.00	0	0	0	28.00
29.00		0.00	0	0	0	29.00
30.00		0.00	0	0	0	30.00
31.00		0.00	0	0	0	31.00
32.00		0.00	0	0	0	32.00
TOTALS			330,103	0		
500.00	Grand Total : Decreases		2,970,126	48,685,732		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140250

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
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	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	714,843	0	0	0	1.00
2.00	Land Improvements	5,355,764	122,515	0	122,515	2.00
3.00	Buildings and Fixtures	120,775,447	3,324,157	0	3,324,157	3.00
4.00	Building Improvements	948,868	0	0	0	4.00
5.00	Fixed Equipment	51,840,309	4,262,837	0	4,262,837	5.00
6.00	Movable Equipment	25,793	0	0	0	6.00
7.00	HIT designated Assets	802,434	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	180,463,458	7,709,509	0	7,709,509	8.00
9.00	Reconciling Items	-11,627,273	2,316,950	0	2,316,950	9.00
10.00	Total (line 8 minus line 9)	192,090,731	5,392,559	0	5,392,559	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	714,843	0			1.00
2.00	Land Improvements	5,478,279	2,604,200			2.00
3.00	Buildings and Fixtures	124,099,604	52,404,928			3.00
4.00	Building Improvements	948,868	269,880			4.00
5.00	Fixed Equipment	54,594,803	26,565,706			5.00
6.00	Movable Equipment	25,793	0			6.00
7.00	HIT designated Assets	802,434	631,147			7.00
8.00	Subtotal (sum of lines 1-7)	186,664,624	82,475,861			8.00
9.00	Reconciling Items	-9,310,323	0			9.00
10.00	Total (line 8 minus line 9)	195,974,947	82,475,861			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140250

Period:  
From 01/01/2015  
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Worksheet A-7  
Part II  
Date/Time Prepared:  
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,595,885	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	4,595,885	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	NEW CAP REL COSTS-BLDG & FIXT	0	4,595,885				1.00
3.00	Total (sum of lines 1-2)	0	4,595,885				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140250

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	0	1	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	1	0	1	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	10,626,392	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	10,626,392	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	10,626,392	1.00
3.00	Total (sum of lines 1-2)	0	0	0	0	10,626,392	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140250

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

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-81,323		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	-5,088,916				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-2,978,855				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-2,853		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)	A	-30,000		UTILIZATION REVIEW-SNF	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		-698,250		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 OTHER NONALLOWABLE EXPENSES	A	-237,343		ADMINISTRATIVE & GENERAL	5.00	0	33.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
33.01 OTHER NONALLOWABLE EXPENSES	A	-67,905	OPERATION OF PLANT	7.00	0	33.01
33.02 OTHER NONALLOWABLE EXPENSES	A	-366	HOUSEKEEPING	9.00	0	33.02
33.03 OTHER NONALLOWABLE EXPENSES	A	-574	CAFETERIA	11.00	0	33.03
33.04 OTHER NONALLOWABLE EXPENSES	A	-1,102	NURSING ADMINISTRATION	13.00	0	33.04
33.05 OTHER NONALLOWABLE EXPENSES	A	-100	PHARMACY	15.00	0	33.05
33.06 OTHER NONALLOWABLE EXPENSES	A	-9	MEDICAL RECORDS & LIBRARY	16.00	0	33.06
33.07 OTHER NONALLOWABLE EXPENSES	A	-26,624	SOCIAL SERVICE	17.00	0	33.07
33.08 OTHER NONALLOWABLE EXPENSES	A	-6,720	ADULTS & PEDIATRICS	30.00	0	33.08
33.09 OTHER NONALLOWABLE EXPENSES	A	-405	OPERATING ROOM	50.00	0	33.09
33.10 OTHER NONALLOWABLE EXPENSES	A	-160	ULTRASOUND	56.01	0	33.10
33.11 OTHER NONALLOWABLE EXPENSES	A	-280	RESPIRATORY THERAPY	65.00	0	33.11
33.12 OTHER NONALLOWABLE EXPENSES	A	-437	EMERGENCY	91.00	0	33.12
34.00		0		0.00	0	34.00
34.05		0		0.00	0	34.05
36.05 AHP FEE	A	-1,507,524	ADMINISTRATIVE & GENERAL	5.00	0	36.05
37.00 BOOKED DEPR TO MC	A	45	NEW CAP REL COSTS-BLDG & FI XT	1.00	9	37.00
37.01 MEDICARE EXCLUDED VENDOR COSTS	A	-2,742	NEW CAP REL COSTS-BLDG & FI XT	1.00	9	37.01
38.00		0		0.00	0	38.00
39.00		0		0.00	0	39.00
39.05		0		0.00	0	39.05
40.03		0		0.00	0	40.03
41.00 ADVERTISING COSTS	A	-39,631	ADMINISTRATIVE & GENERAL	5.00	0	41.00
45.01		0		0.00	0	45.01
45.02 BOOKED INTEREST EXPENSE	A	-1,546,653	INTEREST EXPENSE	113.00	0	45.02
45.06		0		0.00	0	45.06
45.07 HHA EXPENSES	A	-6,601	NONREIMBURSABLE HHA	190.01	0	45.07
45.10		0		0.00	0	45.10
45.15 PUBLIC AID ASSESSMENT	A	-8,079,888	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16		0		0.00	0	45.16
45.17		0		0.00	0	45.17
45.18		0		0.00	0	45.18
45.19 OTHER INCOME	B	-840,030	ADMINISTRATIVE & GENERAL	5.00	0	45.19
45.24 OTHER INCOME	B	-599,341	CAFETERIA	11.00	0	45.24
45.25 OTHER INCOME	B	-12,201	PARAMEDICAL ED PRGM	23.00	0	45.25
45.27 OTHER INCOME	B	-30	ADULTS & PEDIATRICS	30.00	0	45.27
45.28 OTHER INCOME	B	-62,519	RADIOLOGY-DIAGNOSTIC	54.00	0	45.28
45.30 OTHER INCOME	B	-7,738	RADIOISOTOPE	56.00	0	45.30
45.34 OTHER INCOME	B	-362,670	LABORATORY	60.00	0	45.34
45.35 OTHER INCOME	B	-150	PHYSICAL THERAPY	66.00	0	45.35
45.36 OTHER INCOME	B	-2,814	ELECTROCARDIOLOGY	69.00	0	45.36
45.37 OTHER INCOME	B	-90,896	CLINIC	90.00	0	45.37
45.38		0		0.00	0	45.38
45.39		0		0.00	0	45.39
45.40		0		0.00	0	45.40
45.41		0		0.00	0	45.41
45.42		0		0.00	0	45.42
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-22,383,605				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: 140250

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

Worksheet A-8-1

Date/Time Prepared:  
5/26/2016 3:21 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	8,806,443	16,157,338 1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE PERSONNEL ALLOC	2,656,998	0 2.00
3.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE DEPR	1,715,042	0 3.00
4.00	0.00			0	0 4.00
4.01	0.00			0	0 4.01
4.02	0.00			0	0 4.02
5.00	0		0	13,178,483	16,157,338 5.00

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

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

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

(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: 140250

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

Worksheet A-8-1

Date/Time Prepared:  
5/26/2016 3:21 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	-7,350,895	0		1.00
2.00	2,656,998	0		2.00
3.00	1,715,042	9		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	-2,978,855			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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

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

6.00	HOME OFFICE		6.00
7.00			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: 140250

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

Worksheet A-8-2

Date/Time Prepared:  
5/26/2016 3:21 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	2,108,278	2,108,278	0	200,300	0	1.00
2.00	43.00	AGGREGATE-NURSERY	495,000	495,000	0	177,200	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	897,682	897,682	0	177,200	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	1,587,956	1,587,956	0	177,200	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		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			5,088,916	5,088,916	0	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	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	43.00	AGGREGATE-NURSERY	0	0	0	0	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		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	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	2,108,278		1.00
2.00	43.00	AGGREGATE-NURSERY	0	0	0	495,000		2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	897,682		3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	1,587,956		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		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	5,088,916		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140250

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	10,626,392	10,626,392				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	17,589,007	37,687	17,626,694			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	34,126,558	1,198,496	1,517,311	36,842,365	36,842,365	5.00
7.00 00700	OPERATION OF PLANT	6,315,897	2,368,526	513,811	9,198,234	2,244,700	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	148,654	26,648	33,903	209,205	51,054	8.00
9.00 00900	HOUSEKEEPING	2,626,574	114,645	372,946	3,114,165	759,968	9.00
10.00 01000	DIETARY	1,349,686	191,758	243,955	1,785,399	435,702	10.00
11.00 01100	CAFETERIA	948,098	185,577	207,202	1,340,878	327,222	11.00
13.00 01300	NURSING ADMINISTRATION	4,700,836	102,307	1,048,503	5,851,646	1,428,012	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	759,528	93,503	112,368	965,399	235,592	14.00
15.00 01500	PHARMACY	1,587,325	101,866	680,257	2,369,448	578,231	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,035,752	126,982	311,756	2,474,490	603,865	16.00
17.00 01700	SOCIAL SERVICE	890,967	10,259	206,679	1,107,905	270,369	17.00
23.00 02301	PARAMEDICAL ED PRGM	199,407	20,311	43,376	263,094	64,204	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	21,586,085	2,244,868	4,863,477	28,694,430	7,002,465	30.00
31.00 03100	INTENSIVE CARE UNIT	4,946,154	371,387	923,460	6,241,001	1,523,029	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	591,317	43,842	131,315	766,474	187,047	43.00
44.00 04400	SKILLED NURSING FACILITY	2,712,100	414,528	603,750	3,730,378	910,347	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	6,826,791	586,963	1,100,302	8,514,056	2,077,736	50.00
53.00 05300	ANESTHESIOLOGY	247,647	10,389	24,199	282,235	68,876	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,103,878	604,806	1,120,038	6,828,722	1,666,454	54.00
56.00 05600	RADIOISOTOPE	857,718	69,945	70,347	998,010	243,550	56.00
56.01 05601	ULTRASOUND	743,143	0	167,827	910,970	222,309	56.01
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,535,243	99,087	350,748	1,985,078	484,430	59.00
60.00 06000	LABORATORY	6,689,446	248,665	0	6,938,111	1,693,149	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	503,674	28,518	0	532,192	129,874	62.00
64.00 06400	INTRAVENOUS THERAPY	406,999	12,129	86,195	505,323	123,317	64.00
65.00 06500	RESPIRATORY THERAPY	1,704,737	55,764	389,670	2,150,171	524,719	65.00
66.00 06600	PHYSICAL THERAPY	3,090,321	142,514	24,070	3,256,905	794,802	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,381,546	22,311	0	1,403,857	342,592	67.00
68.00 06800	SPEECH PATHOLOGY	254,713	5,273	58,291	318,277	77,671	68.00
69.00 06900	ELECTROCARDIOLOGY	1,198,880	22,648	260,303	1,481,831	361,620	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	89,854	20,623	20,920	131,397	32,066	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,951,865	0	0	12,951,865	3,160,721	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	7,837,666	0	0	7,837,666	1,912,673	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	12,229,626	0	0	12,229,626	2,984,469	73.00
74.00 07400	RENAL DIALYSIS	481,982	39,531	107,040	628,553	153,390	74.00
75.00 07500	ASC (NON-DISTINCT PART)	1,798,866	186,252	353,549	2,338,667	570,719	75.00
76.00 03560	PULMONARY FUNCTION TESTING	103,328	8,207	17,634	129,169	31,522	76.00
76.97 07697	CARDIAC REHABILITATION	376,333	78,049	84,818	539,200	131,584	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	1,751,750	179,473	397,453	2,328,676	568,281	90.00
91.00 09100	EMERGENCY	5,381,959	512,031	1,095,793	6,989,783	1,705,759	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04950	SLEEP LAB	470,749	2,701	75,908	549,358	134,063	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 09910	CORF	0	0	0	0	0	99.10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
112.00 08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0	112.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140250

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	187,759,051	10,589,069	17,626,694	187,721,728	36,819,988	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	54,380	30,778	0	85,158	20,782	190.00
190.01	19001 NONREIMBURSABLE HHA	-8	6,545	0	6,537	1,595	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 FUND RAISING	0	0	0	0	0	194.00
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)	187,813,423	10,626,392	17,626,694	187,813,423	36,842,365	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140250

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	11,442,934				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,427	303,686			8.00
9.00	00900	HOUSEKEEPING	186,831	0	4,060,964		9.00
10.00	01000	DIETARY	312,500	0	113,180	2,646,781	10.00
11.00	01100	CAFETERIA	302,426	0	109,532	0	11.00
13.00	01300	NURSING ADMINISTRATION	166,726	0	60,384	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	152,377	0	55,187	0	14.00
15.00	01500	PHARMACY	166,006	0	60,124	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	206,937	0	74,948	0	16.00
17.00	01700	SOCIAL SERVICE	16,719	0	6,055	0	17.00
23.00	02301	PARAMEDICAL ED PRGM	33,100	0	11,988	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	3,658,366	197,580	1,324,974	1,722,019	30.00
31.00	03100	INTENSIVE CARE UNIT	605,234	31,937	219,201	278,346	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	71,448	17,024	25,877	148,372	43.00
44.00	04400	SKILLED NURSING FACILITY	675,539	57,145	244,664	498,044	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	956,548	0	346,439	0	50.00
53.00	05300	ANESTHESIOLOGY	16,931	0	6,132	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	985,626	0	356,970	0	54.00
56.00	05600	RADIOISOTOPE	113,987	0	41,283	0	56.00
56.01	05601	ULTRASOUND	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	161,477	0	58,483	0	59.00
60.00	06000	LABORATORY	405,239	0	146,768	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	46,475	0	16,832	0	62.00
64.00	06400	INTRAVENOUS THERAPY	19,767	0	7,159	0	64.00
65.00	06500	RESPIRATORY THERAPY	90,876	0	32,913	0	65.00
66.00	06600	PHYSICAL THERAPY	232,248	0	84,115	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	36,359	0	13,168	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,592	0	3,112	0	68.00
69.00	06900	ELECTROCARDIOLOGY	36,909	0	13,368	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	33,608	0	12,172	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	64,422	0	23,332	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	303,527	0	109,930	0	75.00
76.00	03560	PULMONARY FUNCTION TESTING	13,375	0	4,844	0	76.00
76.97	07697	CARDIAC REHABILITATION	127,193	0	46,066	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	292,480	0	105,929	0	90.00
91.00	09100	EMERGENCY	834,434	0	302,212	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04950	SLEEP LAB	4,402	0	1,594	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	112.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,382,111	303,686	4,038,935	2,646,781	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	50,157	0	18,166	0	190.00
190.01	19001	NONREIMBURSABLE HHA	10,666	0	3,863	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140250

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
194.00	07950 FUND RAISING	0	0	0	0	0	194.00
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)	11,442,934	303,686	4,060,964	2,646,781	2,080,057	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140250

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	7,654,753					13.00
14.00	01400	0	1,424,415				14.00
15.00	01500	0	46,497	3,316,317			15.00
16.00	01600	0	4,149	0	3,408,390		16.00
17.00	01700	157,825	5,800	0	0	1,593,843	17.00
23.00	02301	16,604	12,499	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	3,651,774	298,398	53,356	441,282	1,036,968	30.00
31.00	03100	727,655	61,221	11,037	92,156	167,615	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	105,236	1,202	353	13,669	89,347	43.00
44.00	04400	461,782	37,059	3,455	34,055	299,913	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	786,292	588,508	10,692	432,258	0	50.00
53.00	05300	18,479	3,275	31,977	83,633	0	53.00
54.00	05400	9,158	63,631	8,135	460,410	0	54.00
56.00	05600	0	289	146,877	34,485	0	56.00
56.01	05601	0	9,822	120	55,855	0	56.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	193,936	25,470	2,070	95,493	0	59.00
60.00	06000	0	197	0	245,538	0	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	0	0	17,661	0	62.00
64.00	06400	67,192	431	10,188	4,983	0	64.00
65.00	06500	20,594	11,861	149	57,002	0	65.00
66.00	06600	18,210	24,949	13	65,091	0	66.00
67.00	06700	0	0	0	29,718	0	67.00
68.00	06800	0	3,874	0	5,066	0	68.00
69.00	06900	155,639	16,993	978	80,338	0	69.00
70.00	07000	0	275	0	4,167	0	70.00
71.00	07100	0	0	0	94,410	0	71.00
72.00	07200	0	0	0	97,094	0	72.00
73.00	07300	0	0	2,943,739	393,888	0	73.00
74.00	07400	80,816	3,983	293	14,370	0	74.00
75.00	07500	269,116	135,479	23,860	40,451	0	75.00
76.00	03560	0	218	28	844	0	76.00
76.97	07697	17,794	3,059	0	3,761	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	30,495	13,123	2,646	47,482	0	90.00
91.00	09100	866,156	45,701	66,351	450,818	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04950	0	6,337	0	12,412	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
100.00	10000	0	0	0	0	0	100.00
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
112.00	08600	0	0	0	0	0	112.00
113.00	11300	0	0	0	0	0	113.00
114.00	11400	0	0	0	0	0	114.00
118.00		7,654,753	1,424,300	3,316,317	3,408,390	1,593,843	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	115	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140250

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
		13.00	14.00	15.00	16.00	17.00		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	0	0	194.00
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)	7,654,753	1,424,415	3,316,317	3,408,390	1,593,843	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140250

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description		PARAMEDICAL ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400					14.00
15.00	01500					15.00
16.00	01600					16.00
17.00	01700					17.00
23.00	02301	407,611				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	67,935	48,835,984	0	48,835,984	30.00
31.00	03100	67,935	10,156,703	0	10,156,703	31.00
32.00	03200	0	0	0	0	32.00
33.00	03300	0	0	0	0	33.00
34.00	03400	0	0	0	0	34.00
41.00	04100	0	0	0	0	41.00
42.00	04200	0	0	0	0	42.00
43.00	04300	0	1,444,583	0	1,444,583	43.00
44.00	04400	0	7,037,594	0	7,037,594	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	0	13,867,824	0	13,867,824	50.00
53.00	05300	0	514,953	0	514,953	53.00
54.00	05400	0	10,537,187	0	10,537,187	54.00
56.00	05600	0	1,588,410	0	1,588,410	56.00
56.01	05601	0	1,222,763	0	1,222,763	56.01
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
59.00	05900	0	3,055,941	0	3,055,941	59.00
60.00	06000	0	9,429,002	0	9,429,002	60.00
60.01	06001	0	0	0	0	60.01
62.00	06200	0	743,034	0	743,034	62.00
64.00	06400	0	750,526	0	750,526	64.00
65.00	06500	0	2,943,283	0	2,943,283	65.00
66.00	06600	0	4,479,730	0	4,479,730	66.00
67.00	06700	0	1,825,694	0	1,825,694	67.00
68.00	06800	0	424,819	0	424,819	68.00
69.00	06900	0	2,184,415	0	2,184,415	69.00
70.00	07000	0	216,638	0	216,638	70.00
71.00	07100	0	16,206,996	0	16,206,996	71.00
72.00	07200	0	9,847,433	0	9,847,433	72.00
73.00	07300	0	18,551,722	0	18,551,722	73.00
74.00	07400	0	984,267	0	984,267	74.00
75.00	07500	0	3,841,648	0	3,841,648	75.00
76.00	03560	0	182,489	0	182,489	76.00
76.97	07697	0	880,628	0	880,628	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	0	0	0	0	88.00
89.00	08900	0	0	0	0	89.00
90.00	09000	0	3,445,208	0	3,445,208	90.00
91.00	09100	271,741	11,687,614	0	11,687,614	91.00
92.00	09200	0	0	0	0	92.00
93.00	04950	0	718,880	0	718,880	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910	0	0	0	0	99.10
100.00	10000	0	0	0	0	100.00
101.00	10100	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900	0	0	0	0	109.00
110.00	11000	0	0	0	0	110.00
111.00	11100	0	0	0	0	111.00
112.00	08600	0	0	0	0	112.00
113.00	11300	0	0	0	0	113.00
114.00	11400	0	0	0	0	114.00
118.00		407,611	187,616,384	0	187,616,384	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140250

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description			PARAMEDICAL ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	24.00	25.00	26.00	
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	174,378	0	174,378	190.00
190.01	19001	NONREIMBURSABLE HHA	0	22,661	0	22,661	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	407,611	187,813,423	0	187,813,423	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140250

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
		0	1.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	495	37,687	38,182	38,182		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	267,343	1,198,496	1,465,839	3,287	1,469,126	5.00
7.00 00700	OPERATION OF PLANT	143	2,368,526	2,368,669	1,113	89,508	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	26,648	26,648	73	2,036	8.00
9.00 00900	HOUSEKEEPING	4,984	114,645	119,629	808	30,304	9.00
10.00 01000	DIETARY	3,064	191,758	194,822	528	17,374	10.00
11.00 01100	CAFETERIA	0	185,577	185,577	449	13,048	11.00
13.00 01300	NURSING ADMINISTRATION	0	102,307	102,307	2,271	56,942	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	200,406	93,503	293,909	243	9,394	14.00
15.00 01500	PHARMACY	105,728	101,866	207,594	1,474	23,057	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	126,982	126,982	675	24,079	16.00
17.00 01700	SOCIAL SERVICE	0	10,259	10,259	448	10,781	17.00
23.00 02301	PARAMEDICAL ED PRGM	0	20,311	20,311	94	2,560	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	3,130	2,244,868	2,247,998	10,537	279,252	30.00
31.00 03100	INTENSIVE CARE UNIT	0	371,387	371,387	2,000	60,731	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	43,842	43,842	284	7,459	43.00
44.00 04400	SKILLED NURSING FACILITY	600	414,528	415,128	1,308	36,300	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	350	586,963	587,313	2,383	82,850	50.00
53.00 05300	ANESTHESIOLOGY	0	10,389	10,389	52	2,746	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	604,806	604,806	2,426	66,450	54.00
56.00 05600	RADIOISOTOPE	0	69,945	69,945	152	9,712	56.00
56.01 05601	ULTRASOUND	0	0	0	364	8,865	56.01
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	935	99,087	100,022	760	19,317	59.00
60.00 06000	LABORATORY	0	248,665	248,665	0	67,515	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	28,518	28,518	0	5,179	62.00
64.00 06400	INTRAVENOUS THERAPY	0	12,129	12,129	187	4,917	64.00
65.00 06500	RESPIRATORY THERAPY	16,846	55,764	72,610	844	20,923	65.00
66.00 06600	PHYSICAL THERAPY	360	142,514	142,874	52	31,693	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	22,311	22,311	0	13,661	67.00
68.00 06800	SPEECH PATHOLOGY	0	5,273	5,273	126	3,097	68.00
69.00 06900	ELECTROCARDIOLOGY	0	22,648	22,648	564	14,420	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	20,623	20,623	45	1,279	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	126,035	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	76,268	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	119,006	73.00
74.00 07400	RENAL DIALYSIS	0	39,531	39,531	232	6,116	74.00
75.00 07500	ASC (NON-DISTINCT PART)	900	186,252	187,152	766	22,758	75.00
76.00 03560	PULMONARY FUNCTION TESTING	0	8,207	8,207	38	1,257	76.00
76.97 07697	CARDIAC REHABILITATION	0	78,049	78,049	184	5,247	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	179,473	179,473	861	22,660	90.00
91.00 09100	EMERGENCY	0	512,031	512,031	2,374	68,018	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04950	SLEEP LAB	86,647	2,701	89,348	164	5,346	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 09910	CORF	0	0	0	0	0	99.10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
112.00 08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0	112.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	691,931	10,589,069	11,281,000	38,182	1,468,233	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140250

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,778	30,778	0	829	190.00
190.01 19001	NONREIMBURSABLE HHA	0	6,545	6,545	0	64	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 07950	FUND RAISING	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments		0	0			200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	691,931	10,626,392	11,318,323	38,182	1,469,126	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/26/2016 3:21 pm				
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	2,459,290				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	9,333	38,090			8.00	
9.00	00900	HOUSEKEEPING	40,153	0	190,894		9.00	
10.00	01000	DIETARY	67,162	0	5,320	285,206	10.00	
11.00	01100	CAFETERIA	64,997	0	5,149	0	269,220	11.00
13.00	01300	NURSING ADMINISTRATION	35,832	0	2,838	0	19,153	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	32,749	0	2,594	0	2,053	14.00
15.00	01500	PHARMACY	35,678	0	2,826	0	12,426	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,474	0	3,523	0	5,695	16.00
17.00	01700	SOCIAL SERVICE	3,593	0	285	0	3,775	17.00
23.00	02301	PARAMEDICAL ED PRGM	7,114	0	564	0	792	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	786,250	24,782	62,285	185,558	88,852	30.00
31.00	03100	INTENSIVE CARE UNIT	130,075	4,006	10,304	29,993	16,869	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	15,355	2,135	1,216	15,988	2,399	43.00
44.00	04400	SKILLED NURSING FACILITY	145,185	7,167	11,501	53,667	11,029	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	205,579	0	16,285	0	20,099	50.00
53.00	05300	ANESTHESIOLOGY	3,639	0	288	0	442	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	211,829	0	16,780	0	20,459	54.00
56.00	05600	RADIOISOTOPE	24,498	0	1,941	0	1,285	56.00
56.01	05601	ULTRASOUND	0	0	0	0	3,066	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	34,704	0	2,749	0	6,407	59.00
60.00	06000	LABORATORY	87,093	0	6,899	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	9,988	0	791	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	4,248	0	337	0	1,575	64.00
65.00	06500	RESPIRATORY THERAPY	19,531	0	1,547	0	7,118	65.00
66.00	06600	PHYSICAL THERAPY	49,914	0	3,954	0	440	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,814	0	619	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,847	0	146	0	1,065	68.00
69.00	06900	ELECTROCARDIOLOGY	7,932	0	628	0	4,755	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,223	0	572	0	382	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	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	13,845	0	1,097	0	1,955	74.00
75.00	07500	ASC (NON-DISTINCT PART)	65,233	0	5,167	0	6,458	75.00
76.00	03560	PULMONARY FUNCTION TESTING	2,875	0	228	0	322	76.00
76.97	07697	CARDIAC REHABILITATION	27,336	0	2,165	0	1,549	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	62,859	0	4,979	0	7,260	90.00
91.00	09100	EMERGENCY	179,335	0	14,206	0	20,016	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	SLEEP LAB	946	0	75	0	1,387	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0	112.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,446,218	38,090	189,858	285,206	269,220	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,780	0	854	0	0	190.00
190.01	19001	NONREIMBURSABLE HHA	2,292	0	182	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140250		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 5/26/2016 3:21 pm	
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
194.00	07950 FUND RAISING	0	0	0	0	0	194.00
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)	2,459,290	38,090	190,894	285,206	269,220	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140250		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 5/26/2016 3:21 pm	
Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
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	219,343				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	340,942			14.00
15.00	01500	PHARMACY	0	11,129	294,184		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	993	0	206,421	16.00
17.00	01700	SOCIAL SERVICE	4,522	1,388	0	0	35,051
23.00	02301	PARAMEDICAL ED PRGM	476	2,992	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	104,642	71,423	4,733	26,686	22,804
31.00	03100	INTENSIVE CARE UNIT	20,850	14,654	979	5,573	3,686
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	3,015	288	31	827	1,965
44.00	04400	SKILLED NURSING FACILITY	13,232	8,870	306	2,059	6,596
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	22,530	140,863	948	26,141	0
53.00	05300	ANESTHESIOLOGY	530	784	2,837	5,058	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	262	15,230	722	28,146	0
56.00	05600	RADIOISOTOPE	0	69	13,029	2,085	0
56.01	05601	ULTRASOUND	0	2,351	11	3,378	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	5,557	6,097	184	5,775	0
60.00	06000	LABORATORY	0	47	0	14,849	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1,068	0
64.00	06400	INTRAVENOUS THERAPY	1,925	103	904	301	0
65.00	06500	RESPIRATORY THERAPY	590	2,839	13	3,447	0
66.00	06600	PHYSICAL THERAPY	522	5,972	1	3,936	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,797	0
68.00	06800	SPEECH PATHOLOGY	0	927	0	306	0
69.00	06900	ELECTROCARDIOLOGY	4,460	4,067	87	4,858	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	66	0	252	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,709	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	5,872	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	261,133	23,820	0
74.00	07400	RENAL DIALYSIS	2,316	953	26	869	0
75.00	07500	ASC (NON-DISTINCT PART)	7,711	32,428	2,117	2,446	0
76.00	03560	PULMONARY FUNCTION TESTING	0	52	2	51	0
76.97	07697	CARDIAC REHABILITATION	510	732	0	227	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	874	3,141	235	2,871	0
91.00	09100	EMERGENCY	24,819	10,939	5,886	27,263	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04950	SLEEP LAB	0	1,517	0	751	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	219,343	340,914	294,184	206,421	35,051
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	28	0	0	0
190.01	19001	NONREIMBURSABLE HHA	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/26/2016 3:21 pm				
Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
		13.00	14.00	15.00	16.00	17.00		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00	
194.00	07950	FUND RAISING	0	0	0	0	194.00	
200.00		Cross Foot Adjustments					200.00	
201.00		Negative Cost Centers	0	0	0	0	201.00	
202.00		TOTAL (sum lines 118-201)	219,343	340,942	294,184	206,421	35,051	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/26/2016 3:21 pm			
Cost Center Description		PARAMEDICAL ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.00	24.00	25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE				17.00	
23.00	02301	PARAMEDICAL ED PRGM	34,903			23.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	3,915,802	0	3,915,802	30.00	
31.00	03100	INTENSIVE CARE UNIT	671,107	0	671,107	31.00	
32.00	03200	CORONARY CARE UNIT	0	0	0	32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	34.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	42.00	
43.00	04300	NURSERY	94,804	0	94,804	43.00	
44.00	04400	SKILLED NURSING FACILITY	712,348	0	712,348	44.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,104,991	0	1,104,991	50.00	
53.00	05300	ANESTHESIOLOGY	26,765	0	26,765	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	967,110	0	967,110	54.00	
56.00	05600	RADIOISOTOPE	122,716	0	122,716	56.00	
56.01	05601	ULTRASOUND	18,035	0	18,035	56.01	
57.00	05700	CT SCAN	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	181,572	0	181,572	59.00	
60.00	06000	LABORATORY	425,068	0	425,068	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	60.01	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	45,544	0	45,544	62.00	
64.00	06400	INTRAVENOUS THERAPY	26,626	0	26,626	64.00	
65.00	06500	RESPIRATORY THERAPY	129,462	0	129,462	65.00	
66.00	06600	PHYSICAL THERAPY	239,358	0	239,358	66.00	
67.00	06700	OCCUPATIONAL THERAPY	46,202	0	46,202	67.00	
68.00	06800	SPEECH PATHOLOGY	12,787	0	12,787	68.00	
69.00	06900	ELECTROCARDIOLOGY	64,419	0	64,419	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	30,442	0	30,442	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	131,744	0	131,744	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	82,140	0	82,140	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	403,959	0	403,959	73.00	
74.00	07400	RENAL DIALYSIS	66,940	0	66,940	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	332,236	0	332,236	75.00	
76.00	03560	PULMONARY FUNCTION TESTING	13,032	0	13,032	76.00	
76.97	07697	CARDIAC REHABILITATION	115,999	0	115,999	76.97	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00	
90.00	09000	CLINIC	285,213	0	285,213	90.00	
91.00	09100	EMERGENCY	864,887	0	864,887	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00	
93.00	04950	SLEEP LAB	99,534	0	99,534	93.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	99.10	
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	100.00	
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00	
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00	
111.00	11100	ISLET ACQUISITION	0	0	0	111.00	
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	112.00	
113.00	11300	INTEREST EXPENSE	0	0	0	113.00	
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	114.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	11,231,068	0	11,231,068	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140250

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description			PARAMEDICAL ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	24.00	25.00	26.00	
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		43,269	0	43,269	190.00
190.01	19001	NONREIMBURSABLE HHA		9,083	0	9,083	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES		0	0	0	192.00
194.00	07950	FUND RAISING		0	0	0	194.00
200.00		Cross Foot Adjustments	34,903	34,903	0	34,903	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	34,903	11,318,323	0	11,318,323	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140250

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

Worksheet B-1

Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5A	5.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	409,133					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1,451	70,316,913				4.00
5.00 00500 ADMINISTRATIVE & GENERAL	46,144	6,052,900	-36,842,365	150,971,058		5.00
7.00 00700 OPERATION OF PLANT	91,192	2,049,709	0	9,198,234	270,346	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	1,026	135,248	0	209,205	1,026	8.00
9.00 00900 HOUSEKEEPING	4,414	1,487,769	0	3,114,165	4,414	9.00
10.00 01000 DIETARY	7,383	973,191	0	1,785,399	7,383	10.00
11.00 01100 CAFETERIA	7,145	826,576	0	1,340,877	7,145	11.00
13.00 01300 NURSING ADMINISTRATION	3,939	4,182,720	0	5,851,646	3,939	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	3,600	448,262	0	965,399	3,600	14.00
15.00 01500 PHARMACY	3,922	2,713,700	0	2,369,448	3,922	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	4,889	1,243,666	0	2,474,490	4,889	16.00
17.00 01700 SOCIAL SERVICE	395	824,488	0	1,107,905	395	17.00
23.00 02301 PARAMEDICAL ED PRGM	782	173,038	0	263,094	782	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	86,431	19,401,509	0	28,694,430	86,431	30.00
31.00 03100 INTENSIVE CARE UNIT	14,299	3,683,893	0	6,241,001	14,299	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00 04100 SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	1,688	523,847	0	766,474	1,688	43.00
44.00 04400 SKILLED NURSING FACILITY	15,960	2,408,499	0	3,730,378	15,960	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	22,599	4,389,357	0	8,514,056	22,599	50.00
53.00 05300 ANESTHESIOLOGY	400	96,537	0	282,235	400	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	23,286	4,468,089	0	6,828,722	23,286	54.00
56.00 05600 RADIOISOTOPE	2,693	280,629	0	998,010	2,693	56.00
56.01 05601 ULTRASOUND	0	669,500	0	910,970	0	56.01
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	3,815	1,399,213	0	1,985,078	3,815	59.00
60.00 06000 LABORATORY	9,574	0	0	6,938,111	9,574	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,098	0	0	532,192	1,098	62.00
64.00 06400 INTRAVENOUS THERAPY	467	343,853	0	505,323	467	64.00
65.00 06500 RESPIRATORY THERAPY	2,147	1,554,482	0	2,150,171	2,147	65.00
66.00 06600 PHYSICAL THERAPY	5,487	96,021	0	3,256,905	5,487	66.00
67.00 06700 OCCUPATIONAL THERAPY	859	0	0	1,403,857	859	67.00
68.00 06800 SPEECH PATHOLOGY	203	232,537	0	318,277	203	68.00
69.00 06900 ELECTROCARDIOLOGY	872	1,038,407	0	1,481,831	872	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	794	83,456	0	131,397	794	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,951,865	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	7,837,666	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	12,229,626	0	73.00
74.00 07400 RENAL DIALYSIS	1,522	427,009	0	628,553	1,522	74.00
75.00 07500 ASC (NON-DISTINCT PART)	7,171	1,410,386	0	2,338,667	7,171	75.00
76.00 03560 PULMONARY FUNCTION TESTING	316	70,347	0	129,169	316	76.00
76.97 07697 CARDIAC REHABILITATION	3,005	338,360	0	539,200	3,005	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	6,910	1,585,531	0	2,328,676	6,910	90.00
91.00 09100 EMERGENCY	19,714	4,371,369	0	6,989,783	19,714	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 04950 SLEEP LAB	104	302,815	0	549,358	104	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
112.00 08600 OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0	112.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140250

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

Worksheet B-1

Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)		
	NEW BLDG & FIXT (SQUARE FEET)							
	1.00	4.00		5A	5.00	7.00		
118.00	SUBTOTALS (SUM OF LINES 1-117)		407,696	70,316,913	-36,842,365	150,879,363	268,909	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,185	0	0	85,158	1,185	190.00
190.01	19001	NONREIMBURSABLE HHA	252	0	0	6,537	252	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	10,626,392	17,626,694		36,842,365	11,442,934	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.972953	0.250675		0.244036	42.326996	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		38,182		1,469,126	2,459,290	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000543		0.009731	9.096824	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140250

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

Worksheet B-1

Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	
		8.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
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	53,659				8.00
9.00	00900	HOUSEKEEPING	0	264,906			9.00
10.00	01000	DIETARY	0	7,383	53,659		10.00
11.00	01100	CAFETERIA	0	7,145	0	58,791,520	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,939	0	4,182,720	39,244,850
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,600	0	448,262	0
15.00	01500	PHARMACY	0	3,922	0	2,713,700	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,889	0	1,243,666	0
17.00	01700	SOCIAL SERVICE	0	395	0	824,488	809,149
23.00	02301	PARAMEDICAL ED PRGM	0	782	0	173,038	85,128
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	34,911	86,431	34,911	19,401,509	18,722,109
31.00	03100	INTENSIVE CARE UNIT	5,643	14,299	5,643	3,683,893	3,730,590
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	3,008	1,688	3,008	523,847	539,532
44.00	04400	SKILLED NURSING FACILITY	10,097	15,960	10,097	2,408,499	2,367,492
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	22,599	0	4,389,357	4,031,212
53.00	05300	ANESTHESIOLOGY	0	400	0	96,537	94,741
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,286	0	4,468,089	46,952
56.00	05600	RADIOISOTOPE	0	2,693	0	280,629	0
56.01	05601	ULTRASOUND	0	0	0	669,500	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	3,815	0	1,399,213	994,286
60.00	06000	LABORATORY	0	9,574	0	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,098	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	467	0	343,853	344,486
65.00	06500	RESPIRATORY THERAPY	0	2,147	0	1,554,482	105,584
66.00	06600	PHYSICAL THERAPY	0	5,487	0	96,021	93,360
67.00	06700	OCCUPATIONAL THERAPY	0	859	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	203	0	232,537	0
69.00	06900	ELECTROCARDIOLOGY	0	872	0	1,038,407	797,942
70.00	07000	ELECTROENCEPHALOGRAPHY	0	794	0	83,456	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	1,522	0	427,009	414,332
75.00	07500	ASC (NON-DISTINCT PART)	0	7,171	0	1,410,386	1,379,721
76.00	03560	PULMONARY FUNCTION TESTING	0	316	0	70,347	0
76.97	07697	CARDIAC REHABILITATION	0	3,005	0	338,360	91,225
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	6,910	0	1,585,531	156,345
91.00	09100	EMERGENCY	0	19,714	0	4,371,369	4,440,664
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04950	SLEEP LAB	0	104	0	302,815	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	53,659	263,469	53,659	58,791,520	39,244,850

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140250

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

Worksheet B-1

Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	
		8.00	9.00	10.00	11.00	13.00	
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,185	0	0	190.00
190.01	19001	NONREIMBURSABLE HHA	0	252	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	303,686	4,060,964	2,646,781	2,080,057	7,654,753
203.00		Unit cost multiplier (Wkst. B, Part I)	5.659554	15.329830	49.325947	0.035380	0.195051
204.00		Cost to be allocated (per Wkst. B, Part II)	38,090	190,894	285,206	269,220	219,343
205.00		Unit cost multiplier (Wkst. B, Part II)	0.709853	0.720610	5.315157	0.004579	0.005589

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140250

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

Worksheet B-1  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	PARAMEDICAL ED PRGM (ASSIGNED TIME)	
		14.00	15.00	16.00	17.00	23.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400	1,322,497					14.00
15.00	01500	43,170	12,162,050				15.00
16.00	01600	3,852	0	869,794,174			16.00
17.00	01700	5,385	0	0	53,659		17.00
23.00	02301	11,605	0	0	0	24	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	277,047	195,675	112,600,582	34,911	4	30.00
31.00	03100	56,841	40,478	23,515,071	5,643	4	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	1,116	1,296	3,487,806	3,008	0	43.00
44.00	04400	34,407	12,670	8,689,842	10,097	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	546,401	39,212	110,297,975	0	0	50.00
53.00	05300	3,041	117,272	21,340,292	0	0	53.00
54.00	05400	59,078	29,834	117,566,922	0	0	54.00
56.00	05600	268	538,650	8,799,464	0	0	56.00
56.01	05601	9,119	440	14,252,470	0	0	56.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	23,648	7,592	24,366,684	0	0	59.00
60.00	06000	183	0	62,653,292	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	0	4,506,446	0	0	62.00
64.00	06400	400	37,363	1,271,560	0	0	64.00
65.00	06500	11,012	547	14,544,916	0	0	65.00
66.00	06600	23,164	48	16,608,998	0	0	66.00
67.00	06700	0	0	7,583,087	0	0	67.00
68.00	06800	3,597	0	1,292,789	0	0	68.00
69.00	06900	15,777	3,585	20,499,635	0	0	69.00
70.00	07000	255	0	1,063,308	0	0	70.00
71.00	07100	0	0	24,090,339	0	0	71.00
72.00	07200	0	0	24,775,122	0	0	72.00
73.00	07300	0	10,795,676	100,507,238	0	0	73.00
74.00	07400	3,698	1,074	3,666,847	0	0	74.00
75.00	07500	125,785	87,501	10,321,648	0	0	75.00
76.00	03560	202	101	215,276	0	0	76.00
76.97	07697	2,840	0	959,634	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	12,184	9,705	12,115,827	0	0	90.00
91.00	09100	42,431	243,331	115,033,855	0	16	91.00
92.00	09200						92.00
93.00	04950	5,884	0	3,167,249	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
100.00	10000	0	0	0	0	0	100.00
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
112.00	08600	0	0	0	0	0	112.00
113.00	11300	0	0	0	0	0	113.00
114.00	11400	0	0	0	0	0	114.00
118.00		1,322,390	12,162,050	869,794,174	53,659	24	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140250

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

Worksheet B-1

Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	PARAMEDICAL ED PRGM (ASSIGNED TIME)	
		14.00	15.00	16.00	17.00	23.00	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	107	0	0	0	190.00
190.01	19001	NONREIMBURSABLE HHA	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,424,415	3,316,317	3,408,390	1,593,843	407,611
203.00		Unit cost multiplier (Wkst. B, Part I)	1.077065	0.272677	0.003919	29.703181	16,983.791667
204.00		Cost to be allocated (per Wkst. B, Part II)	340,942	294,184	206,421	35,051	34,903
205.00		Unit cost multiplier (Wkst. B, Part II)	0.257802	0.024189	0.000237	0.653218	1,454.291667

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140250

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/26/2016 3:21 pm

		Title XVIIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	48,835,984		48,835,984	0	48,835,984	30.00
31.00	03100 INTENSIVE CARE UNIT	10,156,703		10,156,703	0	10,156,703	31.00
32.00	03200 CORONARY CARE UNIT	0		0	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
41.00	04100 SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
43.00	04300 NURSERY	1,444,583		1,444,583	0	1,444,583	43.00
44.00	04400 SKILLED NURSING FACILITY	7,037,594		7,037,594	0	7,037,594	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	13,867,824		13,867,824	0	13,867,824	50.00
53.00	05300 ANESTHESIOLOGY	514,953		514,953	0	514,953	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,537,187		10,537,187	0	10,537,187	54.00
56.00	05600 RADIOISOTOPE	1,588,410		1,588,410	0	1,588,410	56.00
56.01	05601 ULTRASOUND	1,222,763		1,222,763	0	1,222,763	56.01
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	3,055,941		3,055,941	0	3,055,941	59.00
60.00	06000 LABORATORY	9,429,002		9,429,002	0	9,429,002	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	743,034		743,034	0	743,034	62.00
64.00	06400 INTRAVENOUS THERAPY	750,526		750,526	0	750,526	64.00
65.00	06500 RESPIRATORY THERAPY	2,943,283	0	2,943,283	0	2,943,283	65.00
66.00	06600 PHYSICAL THERAPY	4,479,730	0	4,479,730	0	4,479,730	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,825,694	0	1,825,694	0	1,825,694	67.00
68.00	06800 SPEECH PATHOLOGY	424,819	0	424,819	0	424,819	68.00
69.00	06900 ELECTROCARDIOLOGY	2,184,415		2,184,415	0	2,184,415	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	216,638		216,638	0	216,638	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16,206,996		16,206,996	0	16,206,996	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,847,433		9,847,433	0	9,847,433	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	18,551,722		18,551,722	0	18,551,722	73.00
74.00	07400 RENAL DIALYSIS	984,267		984,267	0	984,267	74.00
75.00	07500 ASC (NON-DISTINCT PART)	3,841,648		3,841,648	0	3,841,648	75.00
76.00	03560 PULMONARY FUNCTION TESTING	182,489		182,489	0	182,489	76.00
76.97	07697 CARDIAC REHABILITATION	880,628		880,628	0	880,628	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	3,445,208		3,445,208	0	3,445,208	90.00
91.00	09100 EMERGENCY	11,687,614		11,687,614	0	11,687,614	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	11,192,443		11,192,443	0	11,192,443	92.00
93.00	04950 SLEEP LAB	718,880		718,880	0	718,880	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910 CORF	0		0	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0		0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0		0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900 PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0		0	0	0	111.00
112.00	08600 OTHER ORGAN ACQUISITION (SPECIF	0		0	0	0	112.00
113.00	11300 INTEREST EXPENSE	0		0	0	0	113.00
114.00	11400 UTILIZATION REVIEW-SNF	0		0	0	0	114.00
200.00	Subtotal (see instructions)	198,808,827	0	198,808,827	0	198,808,827	200.00
201.00	Less Observation Beds	11,192,443		11,192,443	0	11,192,443	201.00
202.00	Total (see instructions)	187,616,384	0	187,616,384	0	187,616,384	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/26/2016 3:21 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	81,332,569		81,332,569	30.00
31.00	03100	INTENSIVE CARE UNIT	23,515,071		23,515,071	31.00
32.00	03200	CORONARY CARE UNIT	0		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	34.00
41.00	04100	SUBPROVIDER - I RF	0		0	41.00
42.00	04200	SUBPROVIDER	0		0	42.00
43.00	04300	NURSERY	3,487,806		3,487,806	43.00
44.00	04400	SKILLED NURSING FACILITY	8,689,842		8,689,842	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	47,159,959	63,138,016	110,297,975	50.00
53.00	05300	ANESTHESIOLOGY	7,936,931	13,403,361	21,340,292	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,055,003	82,511,919	117,566,922	54.00
56.00	05600	RADIO SOTOPE	2,597,973	6,201,491	8,799,464	56.00
56.01	05601	ULTRASOUND	2,149,526	12,102,944	14,252,470	56.01
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,626,623	13,740,061	24,366,684	59.00
60.00	06000	LABORATORY	35,285,351	27,367,941	62,653,292	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,320,559	1,185,887	4,506,446	62.00
64.00	06400	INTRAVENOUS THERAPY	1,139,873	131,687	1,271,560	64.00
65.00	06500	RESPIRATORY THERAPY	12,322,068	2,222,848	14,544,916	65.00
66.00	06600	PHYSICAL THERAPY	8,471,354	8,137,644	16,608,998	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,363,192	2,219,895	7,583,087	67.00
68.00	06800	SPEECH PATHOLOGY	894,032	398,757	1,292,789	68.00
69.00	06900	ELECTROCARDIOLOGY	8,214,253	12,285,382	20,499,635	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	467,292	596,016	1,063,308	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,733,355	9,356,984	24,090,339	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,232,694	10,542,428	24,775,122	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,404,641	34,102,597	100,507,238	73.00
74.00	07400	RENAL DIALYSIS	3,156,645	510,202	3,666,847	74.00
75.00	07500	ASC (NON-DISTINCT PART)	574,788	9,746,860	10,321,648	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0	215,276	215,276	76.00
76.97	07697	CARDIAC REHABILITATION	12,182	947,452	959,634	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	101,451	12,014,376	12,115,827	90.00
91.00	09100	EMERGENCY	23,810,864	91,222,991	115,033,855	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	12,138,873	19,129,140	31,268,013	92.00
93.00	04950	SLEEP LAB	0	3,167,249	3,167,249	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910	CORF	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	112.00
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
200.00		Subtotal (see instructions)	433,194,770	436,599,404	869,794,174	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	433,194,770	436,599,404	869,794,174	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/26/2016 3:21 pm
Cost Center Description		PPS Inpatient Ratio	Title XVII I	Hospital PPS
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
32.00	03200 CORONARY CARE UNIT			32.00
33.00	03300 BURN INTENSIVE CARE UNIT			33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100 SUBPROVIDER - I RF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
	<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	0.125731		50.00
53.00	05300 ANESTHESIOLOGY	0.024131		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.089627		54.00
56.00	05600 RADIOISOTOPE	0.180512		56.00
56.01	05601 ULTRASOUND	0.085793		56.01
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.125415		59.00
60.00	06000 LABORATORY	0.150495		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.164882		62.00
64.00	06400 INTRAVENOUS THERAPY	0.590240		64.00
65.00	06500 RESPIRATORY THERAPY	0.202358		65.00
66.00	06600 PHYSICAL THERAPY	0.269717		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.240759		67.00
68.00	06800 SPEECH PATHOLOGY	0.328607		68.00
69.00	06900 ELECTROCARDIOLOGY	0.106559		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.203740		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.672759		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.397473		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.184581		73.00
74.00	07400 RENAL DIALYSIS	0.268423		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.372193		75.00
76.00	03560 PULMONARY FUNCTION TESTING	0.847698		76.00
76.97	07697 CARDIAC REHABILITATION	0.917671		76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.284356		90.00
91.00	09100 EMERGENCY	0.101602		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.357952		92.00
93.00	04950 SLEEP LAB	0.226973		93.00
	<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10	09910 CORF			99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100 HOME HEALTH AGENCY			101.00
	<b>SPECIAL PURPOSE COST CENTERS</b>			
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
112.00	08600 OTHER ORGAN ACQUISITION (SPECIF			112.00
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
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: 140250

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/26/2016 3:21 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	48,835,984		48,835,984	0	48,835,984	30.00
31.00	03100 INTENSIVE CARE UNIT	10,156,703		10,156,703	0	10,156,703	31.00
32.00	03200 CORONARY CARE UNIT	0		0	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
41.00	04100 SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
43.00	04300 NURSERY	1,444,583		1,444,583	0	1,444,583	43.00
44.00	04400 SKILLED NURSING FACILITY	7,037,594		7,037,594	0	7,037,594	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	13,867,824		13,867,824	0	13,867,824	50.00
53.00	05300 ANESTHESIOLOGY	514,953		514,953	0	514,953	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,537,187		10,537,187	0	10,537,187	54.00
56.00	05600 RADIOISOTOPE	1,588,410		1,588,410	0	1,588,410	56.00
56.01	05601 ULTRASOUND	1,222,763		1,222,763	0	1,222,763	56.01
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	3,055,941		3,055,941	0	3,055,941	59.00
60.00	06000 LABORATORY	9,429,002		9,429,002	0	9,429,002	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	743,034		743,034	0	743,034	62.00
64.00	06400 INTRAVENOUS THERAPY	750,526		750,526	0	750,526	64.00
65.00	06500 RESPIRATORY THERAPY	2,943,283	0	2,943,283	0	2,943,283	65.00
66.00	06600 PHYSICAL THERAPY	4,479,730	0	4,479,730	0	4,479,730	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,825,694	0	1,825,694	0	1,825,694	67.00
68.00	06800 SPEECH PATHOLOGY	424,819	0	424,819	0	424,819	68.00
69.00	06900 ELECTROCARDIOLOGY	2,184,415		2,184,415	0	2,184,415	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	216,638		216,638	0	216,638	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16,206,996		16,206,996	0	16,206,996	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,847,433		9,847,433	0	9,847,433	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	18,551,722		18,551,722	0	18,551,722	73.00
74.00	07400 RENAL DIALYSIS	984,267		984,267	0	984,267	74.00
75.00	07500 ASC (NON-DISTINCT PART)	3,841,648		3,841,648	0	3,841,648	75.00
76.00	03560 PULMONARY FUNCTION TESTING	182,489		182,489	0	182,489	76.00
76.97	07697 CARDIAC REHABILITATION	880,628		880,628	0	880,628	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	3,445,208		3,445,208	0	3,445,208	90.00
91.00	09100 EMERGENCY	11,687,614		11,687,614	0	11,687,614	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	11,192,443		11,192,443	0	11,192,443	92.00
93.00	04950 SLEEP LAB	718,880		718,880	0	718,880	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910 CORF	0		0	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0		0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0		0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900 PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0		0	0	0	111.00
112.00	08600 OTHER ORGAN ACQUISITION (SPECIF	0		0	0	0	112.00
113.00	11300 INTEREST EXPENSE	0		0	0	0	113.00
114.00	11400 UTILIZATION REVIEW-SNF	0		0	0	0	114.00
200.00	Subtotal (see instructions)	198,808,827	0	198,808,827	0	198,808,827	200.00
201.00	Less Observation Beds	11,192,443		11,192,443	0	11,192,443	201.00
202.00	Total (see instructions)	187,616,384	0	187,616,384	0	187,616,384	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140250

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/26/2016 3:21 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	81,332,569		81,332,569		30.00
31.00	03100	INTENSIVE CARE UNIT	23,515,071		23,515,071		31.00
32.00	03200	CORONARY CARE UNIT	0		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
41.00	04100	SUBPROVIDER - I RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	3,487,806		3,487,806		43.00
44.00	04400	SKILLED NURSING FACILITY	8,689,842		8,689,842		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	47,159,959	63,138,016	110,297,975	0.125731	50.00
53.00	05300	ANESTHESIOLOGY	7,936,931	13,403,361	21,340,292	0.024131	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,055,003	82,511,919	117,566,922	0.089627	54.00
56.00	05600	RADIO SOTOPE	2,597,973	6,201,491	8,799,464	0.180512	56.00
56.01	05601	ULTRASOUND	2,149,526	12,102,944	14,252,470	0.085793	56.01
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,626,623	13,740,061	24,366,684	0.125415	59.00
60.00	06000	LABORATORY	35,285,351	27,367,941	62,653,292	0.150495	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,320,559	1,185,887	4,506,446	0.164882	62.00
64.00	06400	INTRAVENOUS THERAPY	1,139,873	131,687	1,271,560	0.590240	64.00
65.00	06500	RESPIRATORY THERAPY	12,322,068	2,222,848	14,544,916	0.202358	65.00
66.00	06600	PHYSICAL THERAPY	8,471,354	8,137,644	16,608,998	0.269717	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,363,192	2,219,895	7,583,087	0.240759	67.00
68.00	06800	SPEECH PATHOLOGY	894,032	398,757	1,292,789	0.328607	68.00
69.00	06900	ELECTROCARDIOLOGY	8,214,253	12,285,382	20,499,635	0.106559	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	467,292	596,016	1,063,308	0.203740	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,733,355	9,356,984	24,090,339	0.672759	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,232,694	10,542,428	24,775,122	0.397473	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,404,641	34,102,597	100,507,238	0.184581	73.00
74.00	07400	RENAL DIALYSIS	3,156,645	510,202	3,666,847	0.268423	74.00
75.00	07500	ASC (NON-DISTINCT PART)	574,788	9,746,860	10,321,648	0.372193	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0	215,276	215,276	0.847698	76.00
76.97	07697	CARDIAC REHABILITATION	12,182	947,452	959,634	0.917671	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	101,451	12,014,376	12,115,827	0.284356	90.00
91.00	09100	EMERGENCY	23,810,864	91,222,991	115,033,855	0.101602	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	12,138,873	19,129,140	31,268,013	0.357952	92.00
93.00	04950	SLEEP LAB	0	3,167,249	3,167,249	0.226973	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0		112.00
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (see instructions)	433,194,770	436,599,404	869,794,174		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	433,194,770	436,599,404	869,794,174		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/26/2016 3:21 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
32.00	03200 CORONARY CARE UNIT			32.00
33.00	03300 BURN INTENSIVE CARE UNIT			33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100 SUBPROVIDER - I RF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
	<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
56.01	05601 ULTRASOUND	0.000000		56.01
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03560 PULMONARY FUNCTION TESTING	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04950 SLEEP LAB	0.000000		93.00
	<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10	09910 CORF			99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100 HOME HEALTH AGENCY			101.00
	<b>SPECIAL PURPOSE COST CENTERS</b>			
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
112.00	08600 OTHER ORGAN ACQUISITION (SPECIF			112.00
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
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: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part I Date/Time Prepared: 5/26/2016 3:21 pm
		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	3,915,802	0	3,915,802	45,291	86.46	30.00
31.00	INTENSIVE CARE UNIT	671,107		671,107	5,643	118.93	31.00
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	94,804		94,804	3,008	31.52	43.00
44.00	SKILLED NURSING FACILITY	712,348		712,348	10,097	70.55	44.00
200.00	Total (lines 30-199)	5,394,061		5,394,061	64,039		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	13,358	1,154,933				
31.00	INTENSIVE CARE UNIT	2,390	284,243				
32.00	CORONARY CARE UNIT	0	0				
33.00	BURN INTENSIVE CARE UNIT	0	0				
34.00	SURGICAL INTENSIVE CARE UNIT	0	0				
41.00	SUBPROVIDER - IRF	0	0				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	5,873	414,340				
200.00	Total (lines 30-199)	21,621	1,853,516				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 5/26/2016 3:21 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,104,991	110,297,975	0.010018	14,525,181	145,513	50.00
53.00	05300 ANESTHESIOLOGY	26,765	21,340,292	0.001254	2,064,205	2,589	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	967,110	117,566,922	0.008226	13,148,578	108,160	54.00
56.00	05600 RADIOISOTOPE	122,716	8,799,464	0.013946	970,634	13,536	56.00
56.01	05601 ULTRASOUND	18,035	14,252,470	0.001265	655,929	830	56.01
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	181,572	24,366,684	0.007452	3,991,887	29,748	59.00
60.00	06000 LABORATORY	425,068	62,653,292	0.006784	12,316,748	83,557	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	45,544	4,506,446	0.010106	1,036,057	10,470	62.00
64.00	06400 INTRAVENOUS THERAPY	26,626	1,271,560	0.020940	406,134	8,504	64.00
65.00	06500 RESPIRATORY THERAPY	129,462	14,544,916	0.008901	5,419,729	48,241	65.00
66.00	06600 PHYSICAL THERAPY	239,358	16,608,998	0.014411	2,156,115	31,072	66.00
67.00	06700 OCCUPATIONAL THERAPY	46,202	7,583,087	0.006093	604,442	3,683	67.00
68.00	06800 SPEECH PATHOLOGY	12,787	1,292,789	0.009891	376,742	3,726	68.00
69.00	06900 ELECTROCARDIOLOGY	64,419	20,499,635	0.003142	3,385,733	10,638	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	30,442	1,063,308	0.028630	201,319	5,764	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	131,744	24,090,339	0.005469	5,346,469	29,240	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	82,140	24,775,122	0.003315	5,077,433	16,832	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	403,959	100,507,238	0.004019	22,299,220	89,621	73.00
74.00	07400 RENAL DIALYSIS	66,940	3,666,847	0.018255	1,743,483	31,827	74.00
75.00	07500 ASC (NON-DISTINCT PART)	332,236	10,321,648	0.032188	229,371	7,383	75.00
76.00	03560 PULMONARY FUNCTION TESTING	13,032	215,276	0.060536	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	115,999	959,634	0.120878	6,082	735	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	285,213	12,115,827	0.023541	28,697	676	90.00
91.00	09100 EMERGENCY	864,887	115,033,855	0.007519	9,669,554	72,705	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	897,444	31,268,013	0.028702	4,512,418	129,515	92.00
93.00	04950 SLEEP LAB	99,534	3,167,249	0.031426	0	0	93.00
200.00	Total (lines 50-199)	6,734,225	752,768,886		110,172,160	884,565	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part III Date/Time Prepared: 5/26/2016 3:21 pm
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Cost Center Description			Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	67,935	0	0	67,935	30.00
31.00	03100	INTENSIVE CARE UNIT	0	67,935	0	0	67,935	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	135,870	0	0	135,870	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	45,291	1.50	13,358	20,037		30.00
31.00	03100	INTENSIVE CARE UNIT	5,643	12.04	2,390	28,776		31.00
32.00	03200	CORONARY CARE UNIT	0	0.00	0	0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0.00	0	0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0.00	0	0		34.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	3,008	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	10,097	0.00	5,873	0		44.00
200.00		Total (lines 30-199)	64,039		21,621	48,813		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140250

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
56.01	05601	ULTRASOUND	0	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	271,741	0	271,741	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	15,569	0	15,569	0	92.00
93.00	04950	SLEEP LAB	0	0	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	287,310	0	287,310	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/26/2016 3:21 pm
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Cost Center Description		Title XVIII			Hospital		PPS
		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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	110,297,975	0.000000	0.000000	14,525,181	50.00
53.00	05300 ANESTHESIOLOGY	0	21,340,292	0.000000	0.000000	2,064,205	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	117,566,922	0.000000	0.000000	13,148,578	54.00
56.00	05600 RADIOISOTOPE	0	8,799,464	0.000000	0.000000	970,634	56.00
56.01	05601 ULTRASOUND	0	14,252,470	0.000000	0.000000	655,929	56.01
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	24,366,684	0.000000	0.000000	3,991,887	59.00
60.00	06000 LABORATORY	0	62,653,292	0.000000	0.000000	12,316,748	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,506,446	0.000000	0.000000	1,036,057	62.00
64.00	06400 INTRAVENOUS THERAPY	0	1,271,560	0.000000	0.000000	406,134	64.00
65.00	06500 RESPIRATORY THERAPY	0	14,544,916	0.000000	0.000000	5,419,729	65.00
66.00	06600 PHYSICAL THERAPY	0	16,608,998	0.000000	0.000000	2,156,115	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	7,583,087	0.000000	0.000000	604,442	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,292,789	0.000000	0.000000	376,742	68.00
69.00	06900 ELECTROCARDIOLOGY	0	20,499,635	0.000000	0.000000	3,385,733	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1,063,308	0.000000	0.000000	201,319	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,090,339	0.000000	0.000000	5,346,469	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	24,775,122	0.000000	0.000000	5,077,433	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	100,507,238	0.000000	0.000000	22,299,220	73.00
74.00	07400 RENAL DIALYSIS	0	3,666,847	0.000000	0.000000	1,743,483	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	10,321,648	0.000000	0.000000	229,371	75.00
76.00	03560 PULMONARY FUNCTION TESTING	0	215,276	0.000000	0.000000	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	959,634	0.000000	0.000000	6,082	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	12,115,827	0.000000	0.000000	28,697	90.00
91.00	09100 EMERGENCY	271,741	115,033,855	0.002362	0.002362	9,669,554	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	15,569	31,268,013	0.000498	0.000498	4,512,418	92.00
93.00	04950 SLEEP LAB	0	3,167,249	0.000000	0.000000	0	93.00
200.00	Total (lines 50-199)	287,310	752,768,886			110,172,160	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/26/2016 3:21 pm
	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	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	12,261,506	0	50.00
53.00 05300 ANESTHESIOLOGY	0	2,608,430	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	16,635,155	0	54.00
56.00 05600 RADIO SOTOPE	0	1,748,177	0	56.00
56.01 05601 ULTRASOUND	0	1,215,410	0	56.01
57.00 05700 CT SCAN	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	4,488,693	0	59.00
60.00 06000 LABORATORY	0	4,538,740	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	247,447	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0	30,671	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	540,083	0	65.00
66.00 06600 PHYSICAL THERAPY	0	34,928	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	29,522	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	10,750	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	2,931,902	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	128,487	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,363,058	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	2,625,544	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	9,498,296	0	73.00
74.00 07400 RENAL DIALYSIS	0	287,117	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	2,003,933	0	75.00
76.00 03560 PULMONARY FUNCTION TESTING	0	120,466	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	298,790	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 09000 CLINIC	0	3,770,668	0	90.00
91.00 09100 EMERGENCY	22,839	12,230,787	28,889	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,247	4,312,184	2,147	92.00
93.00 04950 SLEEP LAB	0	603,829	0	93.00
200.00 Total (lines 50-199)	25,086	85,564,573	31,036	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/26/2016 3:21 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.125731	12,261,506	0	0	1,541,651	50.00
53.00	05300 ANESTHESIOLOGY	0.024131	2,608,430	0	0	62,944	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.089627	16,635,155	0	1,713	1,490,959	54.00
56.00	05600 RADIOISOTOPE	0.180512	1,748,177	0	0	315,567	56.00
56.01	05601 ULTRASOUND	0.085793	1,215,410	0	0	104,274	56.01
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.125415	4,488,693	0	14,710	562,949	59.00
60.00	06000 LABORATORY	0.150495	4,538,740	0	5,631	683,058	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.164882	247,447	0	0	40,800	62.00
64.00	06400 INTRAVENOUS THERAPY	0.590240	30,671	0	0	18,103	64.00
65.00	06500 RESPIRATORY THERAPY	0.202358	540,083	0	0	109,290	65.00
66.00	06600 PHYSICAL THERAPY	0.269717	34,928	0	0	9,421	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.240759	29,522	0	0	7,108	67.00
68.00	06800 SPEECH PATHOLOGY	0.328607	10,750	0	0	3,533	68.00
69.00	06900 ELECTROCARDIOLOGY	0.106559	2,931,902	0	739	312,421	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.203740	128,487	0	0	26,178	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.672759	2,363,058	0	365	1,589,769	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.397473	2,625,544	0	402,900	1,043,583	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.184581	9,498,296	0	73,487	1,753,205	73.00
74.00	07400 RENAL DIALYSIS	0.268423	287,117	0	0	77,069	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.372193	2,003,933	0	0	745,850	75.00
76.00	03560 PULMONARY FUNCTION TESTING	0.847698	120,466	0	0	102,119	76.00
76.97	07697 CARDIAC REHABILITATION	0.917671	298,790	0	0	274,191	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000 CLINIC	0.284356	3,770,668	0	0	1,072,212	90.00
91.00	09100 EMERGENCY	0.101602	12,230,787	0	0	1,242,672	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.357952	4,312,184	0	0	1,543,555	92.00
93.00	04950 SLEEP LAB	0.226973	603,829	0	0	137,053	93.00
200.00	Subtotal (see instructions)		85,564,573	0	499,545	14,869,534	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		85,564,573	0	499,545	14,869,534	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/26/2016 3:21 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	154		54.00
56.00 05600 RADIOISOTOPE	0	0		56.00
56.01 05601 ULTRASOUND	0	0		56.01
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	1,845		59.00
60.00 06000 LABORATORY	0	847		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	79		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	246		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	160,142		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	13,564		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.00 03560 PULMONARY FUNCTION TESTING	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00 04950 SLEEP LAB	0	0		93.00
200.00	Subtotal (see instructions)	0	176,877	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (Line 200 +/- Line 201)	0	176,877	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140250  
Component CCN: 145599

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/26/2016 3:21 pm

Title XVIII

Skilled Nursing Facility

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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
56.01	05601	ULTRASOUND	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	271,741	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04950	SLEEP LAB	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	271,741	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140250 Component CCN: 145599	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/26/2016 3:21 pm
		Title XVIII	Skilled Nursing Facility 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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	110,297,975	0.000000	0.000000	6,767	50.00
53.00	05300 ANESTHESIOLOGY	0	21,340,292	0.000000	0.000000	3,271	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	117,566,922	0.000000	0.000000	166,508	54.00
56.00	05600 RADIOISOTOPE	0	8,799,464	0.000000	0.000000	14,386	56.00
56.01	05601 ULTRASOUND	0	14,252,470	0.000000	0.000000	21,966	56.01
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	24,366,684	0.000000	0.000000	8,808	59.00
60.00	06000 LABORATORY	0	62,653,292	0.000000	0.000000	703,584	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,506,446	0.000000	0.000000	21,591	62.00
64.00	06400 INTRAVENOUS THERAPY	0	1,271,560	0.000000	0.000000	19,601	64.00
65.00	06500 RESPIRATORY THERAPY	0	14,544,916	0.000000	0.000000	469,112	65.00
66.00	06600 PHYSICAL THERAPY	0	16,608,998	0.000000	0.000000	2,325,417	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	7,583,087	0.000000	0.000000	2,451,192	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,292,789	0.000000	0.000000	95,563	68.00
69.00	06900 ELECTROCARDIOLOGY	0	20,499,635	0.000000	0.000000	36,703	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1,063,308	0.000000	0.000000	1,652	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,090,339	0.000000	0.000000	564,045	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	24,775,122	0.000000	0.000000	3,509	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	100,507,238	0.000000	0.000000	1,617,843	73.00
74.00	07400 RENAL DIALYSIS	0	3,666,847	0.000000	0.000000	8,561	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	10,321,648	0.000000	0.000000	1,700	75.00
76.00	03560 PULMONARY FUNCTION TESTING	0	215,276	0.000000	0.000000	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	959,634	0.000000	0.000000	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	12,115,827	0.000000	0.000000	14,768	90.00
91.00	09100 EMERGENCY	271,741	115,033,855	0.002362	0.002362	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	31,268,013	0.000000	0.000000	0	92.00
93.00	04950 SLEEP LAB	0	3,167,249	0.000000	0.000000	0	93.00
200.00	Total (Lines 50-199)	271,741	752,768,886			8,556,547	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/26/2016 3:21 pm
	Component CCN: 145599	Title XVIII	Skilled Nursing Facility 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	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	56.00
56.01	05601 ULTRASOUND	0	0	0	56.01
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	03560 PULMONARY FUNCTION TESTING	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04950 SLEEP LAB	0	0	0	93.00
200.00	Total (Lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/26/2016 3:21 pm
		Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.125731	0	0	2,689,965	0 50.00
53.00 05300 ANESTHESIOLOGY	0.024131	0	0	524,765	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.089627	0	0	5,718,955	0 54.00
56.00 05600 RADIOISOTOPE	0.180512	0	0	287,442	0 56.00
56.01 05601 ULTRASOUND	0.085793	0	0	1,618,571	0 56.01
57.00 05700 CT SCAN	0.000000	0	0	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.125415	0	0	376,496	0 59.00
60.00 06000 LABORATORY	0.150495	0	0	2,548,419	0 60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.164882	0	0	83,996	0 62.00
64.00 06400 INTRAVENOUS THERAPY	0.590240	0	0	6,840	0 64.00
65.00 06500 RESPIRATORY THERAPY	0.202358	0	0	201,643	0 65.00
66.00 06600 PHYSICAL THERAPY	0.269717	0	0	433,559	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.240759	0	0	178,692	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.328607	0	0	25,828	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0.106559	0	0	703,952	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.203740	0	0	41,253	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.672759	0	0	396,456	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.397473	0	0	363,663	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.184581	0	0	2,460,858	0 73.00
74.00 07400 RENAL DIALYSIS	0.268423	0	0	16,699	0 74.00
75.00 07500 ASC (NON-DISTINCT PART)	0.372193	0	0	328,083	0 75.00
76.00 03560 PULMONARY FUNCTION TESTING	0.847698	0	0	25	0 76.00
76.97 07697 CARDIAC REHABILITATION	0.917671	0	0	26,683	0 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0 88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0 89.00
90.00 09000 CLINIC	0.284356	0	0	463,853	0 90.00
91.00 09100 EMERGENCY	0.101602	0	0	13,464,079	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.357952	0	0	1,656,673	0 92.00
93.00 04950 SLEEP LAB	0.226973	0	0	113,094	0 93.00
200.00	Subtotal (see instructions)	0	0	34,730,542	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	34,730,542	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/26/2016 3:21 pm
		Title XIX	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	338,212	50.00
53.00	05300	ANESTHESIOLOGY	0	12,663	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	512,573	54.00
56.00	05600	RADIOISOTOPE	0	51,887	56.00
56.01	05601	ULTRASOUND	0	138,862	56.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	47,218	59.00
60.00	06000	LABORATORY	0	383,524	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	13,849	62.00
64.00	06400	INTRAVENOUS THERAPY	0	4,037	64.00
65.00	06500	RESPIRATORY THERAPY	0	40,804	65.00
66.00	06600	PHYSICAL THERAPY	0	116,938	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	43,022	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,487	68.00
69.00	06900	ELECTROCARDIOLOGY	0	75,012	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,405	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	266,719	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	144,546	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	454,228	73.00
74.00	07400	RENAL DIALYSIS	0	4,482	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	122,110	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0	21	76.00
76.97	07697	CARDIAC REHABILITATION	0	24,486	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	131,899	90.00
91.00	09100	EMERGENCY	0	1,367,977	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	593,009	92.00
93.00	04950	SLEEP LAB	0	25,669	93.00
200.00		Subtotal (see instructions)	0	4,930,639	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	4,930,639	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/26/2016 3:21 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		45,291	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		45,291	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)		34,911	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		13,358	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
<b>SWING BED ADJUSTMENT</b>				
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)		48,835,984	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)		48,835,984	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		48,835,984	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,078.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		14,403,531	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		14,403,531	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140250		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/26/2016 3:21 pm	
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	10,156,703	5,643	1,799.88	2,390	4,301,713		43.00
44.00 CORONARY CARE UNIT	0	0	0.00	0	0		44.00
45.00 BURN INTENSIVE CARE UNIT	0	0	0.00	0	0		45.00
46.00 SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0		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)					21,296,032		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					40,001,276		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)					1,487,989		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					909,651		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,397,640		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					37,603,636		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					10,380		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,078.27		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					11,192,443		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140250		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/26/2016 3:21 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,915,802	48,835,984	0.080183	11,192,443	897,444	90.00
91.00	Nursing School cost	0	48,835,984	0.000000	11,192,443	0	91.00
92.00	Allied health cost	67,935	48,835,984	0.001391	11,192,443	15,569	92.00
93.00	All other Medical Education	0	48,835,984	0.000000	11,192,443	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140250 Component CCN: 145599	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/26/2016 3:21 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,097	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,097	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)		10,097	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)		5,873	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
<b>SWING BED ADJUSTMENT</b>				
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)		7,037,594	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)		7,037,594	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		7,037,594	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1	
		Component CCN: 145599		Date/Time Prepared: 5/26/2016 3:21 pm	
		Title XVIII	Skilled Nursing Facility	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)				42.00
	Intensive Care Type Inpatient Hospital Units				
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
	Cost Center Description				
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				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)				50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				53.00
	TARGET AMOUNT AND LIMIT COMPUTATION				
54.00	Program discharges				54.00
55.00	Target amount per discharge				55.00
56.00	Target amount (line 54 x line 55)				56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				57.00
58.00	Bonus payment (see instructions)				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				59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				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)				61.00
62.00	Relief payment (see instructions)				62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				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)				64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				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)				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)				68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY				
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)				7,037,594 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				697.00 71.00
72.00	Program routine service cost (line 9 x line 71)				4,093,481 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				4,093,481 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)				0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0 80.00
81.00	Inpatient routine service cost per diem limitation				0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)				4,093,481 83.00
84.00	Program inpatient ancillary services (see instructions)				2,177,001 84.00
85.00	Utilization review - physician compensation (see instructions)				30,000 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				6,300,482 86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				
87.00	Total observation bed days (see instructions)				0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140250 Component CCN: 145599		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/26/2016 3:21 pm	
		Title XVIII		Skilled Nursing Facility		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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 140250

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

Worksheet D-2  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day All Patients	Average Cost Per Day	Health Care Program Inpatient Days Title V																																																																																																											
	1.00	2.00	3.00	4.00	5.00																																																																																																											
<b>PART I - NOT IN APPROVED TEACHING PROGRAM</b>																																																																																																																
Hospital Inpatient Routine Services:																																																																																																																
1.00 Total cost of services rendered	100.00	0			1.00																																																																																																											
2.00 ADULTS & PEDIATRICS	100.00	0	45,291	0.00	2.00																																																																																																											
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11.00 SUBPROVIDER - IRF	0.00	0	0	0.00	11.00																																																																																																											
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Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)																																																																																																											
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APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 140250

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

Worksheet D-2

Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description	Not In Approved Teaching Program		In Approved Teaching Program	
	(from Part I:)	Amount	(from Part II, col. 7, - )	
	1.00	2.00	3.00	
<b>PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)</b>				
<b>Hospital</b>				
43.00 Inpatient	col. 9, line 9.00		0 line 37.00	43.00
44.00 Outpatient	col. 9, line 27.00		0	44.00
45.00 Total Hospital (sum of lines 43 and 44)			0	45.00
46.00 SUBPROVIDER - IPF				46.00
47.00 SUBPROVIDER - IRF	col. 9, line 11.00		0 col. 9, line 39.00	47.00
48.00 SUBPROVIDER	col. 9, line 12.00		0 col. 9, line 40.00	48.00
49.00 SKILLED NURSING FACILITY	col. 9, line 13.00		0 col. 9, line 41.00	49.00

Cost Center Description	Health Care Program Inpatient Days		Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
	Title XVIII, Part B Only Less Part A Coverage but no Part B Coverage	Title XIX				
	6.00	7.00				
<b>PART I - NOT IN APPROVED TEACHING PROGRAM</b>						
1.00	Total cost of services rendered					1.00
Hospital Inpatient Routine Services:						
2.00	ADULTS & PEDIATRICS	13,358	0	0	0	2.00
3.00	INTENSIVE CARE UNIT	2,390	389	0	0	3.00
4.00	CORONARY CARE UNIT	0	0	0	0	4.00
5.00	BURN INTENSIVE CARE UNIT	0	0	0	0	5.00
6.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	6.00
7.00	OTHER SPECIAL CARE (SPECIFY)					7.00
8.00	NURSERY		0	0	0	8.00
9.00	Subtotal (sum of lines 2 through 8)			0	0	9.00
10.00	SUBPROVIDER - IPF			0	0	10.00
11.00	SUBPROVIDER - IRF	0	0	0	0	11.00
12.00	SUBPROVIDER	0	0	0	0	12.00
13.00	SKILLED NURSING FACILITY	5,873	0	0	0	13.00
14.00	NURSING FACILITY					14.00
15.00	OTHER LONG TERM CARE					15.00
16.00	HOME HEALTH AGENCY					16.00
17.00	CMHC					17.00
17.10	CORF					17.10
18.00	AMBULATORY SURGICAL CENTER (D.P.)					18.00
19.00	HOSPICE					19.00
20.00	Subtotal (sum of lines 9 through 19)					20.00
Cost Center Description		Titles V and XIX Outpatient and Title XVIII Part B Charges		Titles V and XIX Outpatient and Title XVIII Part B Cost		
		Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX
		6.00	7.00	8.00	9.00	10.00
Hospital Outpatient Services:						
21.00	RURAL HEALTH CLINIC	0	0	0	0	21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	22.00
23.00	CLINIC	3,799,365	467,759	0	0	23.00
24.00	EMERGENCY	21,900,341	14,902,548	0	0	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)	8,824,602	2,517,339	0	0	25.00
26.00	SLEEP LAB	603,829	113,094	0	0	26.00
27.00	Subtotal (sum of lines 21 through 26)			0	0	27.00
28.00	Total (sum of lines 20 and 27)					28.00
Cost Center Description		Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents		
		6.00	7.00	11.00		
<b>PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)</b>						
Hospital Inpatient Routine Services:						
29.00	ADULTS & PEDIATRICS	0	0	0		29.00
30.00	Swing Bed - SNF	0	0			30.00
31.00	Swing Bed - NF					31.00
32.00	INTENSIVE CARE UNIT	0	0	0		32.00
33.00	CORONARY CARE UNIT	0	0	0		33.00
34.00	BURN INTENSIVE CARE UNIT	0	0	0		34.00
35.00	SURGICAL INTENSIVE CARE UNIT	0	0	0		35.00
36.00	OTHER SPECIAL CARE (SPECIFY)					36.00
37.00	Subtotal (sum of lines 28, and 29 through 36)		0	0		37.00
38.00	SUBPROVIDER - IPF					38.00
39.00	SUBPROVIDER - IRF	0	0	0		39.00
40.00	SUBPROVIDER	0	0	0		40.00
41.00	SKILLED NURSING FACILITY	0	0	0		41.00
42.00	Total (sum of lines 37 through 41)		0	0		42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 140250

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

Worksheet D-2

Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description	In Approved Teaching Program	Total Title XVIII Costs			
	Amount	(to Wkst. E, Part B - )	(col. 2 + col. 4)		
	4.00	5.00	6.00		
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)					
Hospital					
43.00	Inpatient	0		0	43.00
44.00	Outpatient				44.00
45.00	Total Hospital (sum of lines 43 and 44)	0	line 2.00	0	45.00
46.00	SUBPROVIDER - IPF				46.00
47.00	SUBPROVIDER - IRF	0	line 2.00	0	47.00
48.00	SUBPROVIDER	0	line 2.00	0	48.00
49.00	SKILLED NURSING FACILITY	0	line 2.00	0	49.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/26/2016 3:21 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		26,659,517	30.00
31.00	03100	INTENSIVE CARE UNIT		9,863,402	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.125731	14,525,181	1,826,266 50.00
53.00	05300	ANESTHESIOLOGY	0.024131	2,064,205	49,811 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089627	13,148,578	1,178,468 54.00
56.00	05600	RADIOISOTOPE	0.180512	970,634	175,211 56.00
56.01	05601	ULTRASOUND	0.085793	655,929	56,274 56.01
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.125415	3,991,887	500,643 59.00
60.00	06000	LABORATORY	0.150495	12,316,748	1,853,609 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.164882	1,036,057	170,827 62.00
64.00	06400	INTRAVENOUS THERAPY	0.590240	406,134	239,717 64.00
65.00	06500	RESPIRATORY THERAPY	0.202358	5,419,729	1,096,726 65.00
66.00	06600	PHYSICAL THERAPY	0.269717	2,156,115	581,541 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.240759	604,442	145,525 67.00
68.00	06800	SPEECH PATHOLOGY	0.328607	376,742	123,800 68.00
69.00	06900	ELECTROCARDIOLOGY	0.106559	3,385,733	360,780 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.203740	201,319	41,017 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.672759	5,346,469	3,596,885 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.397473	5,077,433	2,018,143 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184581	22,299,220	4,116,012 73.00
74.00	07400	RENAL DIALYSIS	0.268423	1,743,483	467,991 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.372193	229,371	85,370 75.00
76.00	03560	PULMONARY FUNCTION TESTING	0.847698	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0.917671	6,082	5,581 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000	CLINIC	0.284356	28,697	8,160 90.00
91.00	09100	EMERGENCY	0.101602	9,669,554	982,446 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.357952	4,512,418	1,615,229 92.00
93.00	04950	SLEEP LAB	0.226973	0	0 93.00
200.00		Total (sum of lines 50-94 and 96-98)		110,172,160	21,296,032 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		110,172,160	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3	
		Component CCN: 145599		Date/Time Prepared: 5/26/2016 3:21 pm	
		Title XVIII	Skilled Nursing Facility	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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.125731	6,767	851 50.00
53.00	05300	ANESTHESIOLOGY	0.024131	3,271	79 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089627	166,508	14,924 54.00
56.00	05600	RADIOISOTOPE	0.180512	14,386	2,597 56.00
56.01	05601	ULTRASOUND	0.085793	21,966	1,885 56.01
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.125415	8,808	1,105 59.00
60.00	06000	LABORATORY	0.150495	703,584	105,886 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.164882	21,591	3,560 62.00
64.00	06400	INTRAVENOUS THERAPY	0.590240	19,601	11,569 64.00
65.00	06500	RESPIRATORY THERAPY	0.202358	469,112	94,929 65.00
66.00	06600	PHYSICAL THERAPY	0.269717	2,325,417	627,204 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.240759	2,451,192	590,147 67.00
68.00	06800	SPEECH PATHOLOGY	0.328607	95,563	31,403 68.00
69.00	06900	ELECTROCARDIOLOGY	0.106559	36,703	3,911 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.203740	1,652	337 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.672759	564,045	379,466 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.397473	3,509	1,395 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184581	1,617,843	298,623 73.00
74.00	07400	RENAL DIALYSIS	0.268423	8,561	2,298 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.372193	1,700	633 75.00
76.00	03560	PULMONARY FUNCTION TESTING	0.847698	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0.917671	0	0 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000	CLINIC	0.284356	14,768	4,199 90.00
91.00	09100	EMERGENCY	0.101602	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.357952	0	0 92.00
93.00	04950	SLEEP LAB	0.226973	0	0 93.00
200.00		Total (sum of lines 50-94 and 96-98)		8,556,547	2,177,001 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		8,556,547	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/26/2016 3:21 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		6,700,925	30.00
31.00	03100	INTENSIVE CARE UNIT		1,356,661	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		1,370,776	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.125731	1,892,792	237,983 50.00
53.00	05300	ANESTHESIOLOGY	0.024131	659,077	15,904 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089627	2,089,845	187,307 54.00
56.00	05600	RADIOISOTOPE	0.180512	132,885	23,987 56.00
56.01	05601	ULTRASOUND	0.085793	207,835	17,831 56.01
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.125415	420,414	52,726 59.00
60.00	06000	LABORATORY	0.150495	2,711,773	408,108 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.164882	291,526	48,067 62.00
64.00	06400	INTRAVENOUS THERAPY	0.590240	76,067	44,898 64.00
65.00	06500	RESPIRATORY THERAPY	0.202358	678,472	137,294 65.00
66.00	06600	PHYSICAL THERAPY	0.269717	128,397	34,631 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.240759	35,778	8,614 67.00
68.00	06800	SPEECH PATHOLOGY	0.328607	36,391	11,958 68.00
69.00	06900	ELECTROCARDIOLOGY	0.106559	373,585	39,809 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.203740	20,727	4,223 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.672759	673,442	453,064 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.397473	277,500	110,299 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184581	4,040,552	745,809 73.00
74.00	07400	RENAL DIALYSIS	0.268423	117,990	31,671 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.372193	39,181	14,583 75.00
76.00	03560	PULMONARY FUNCTION TESTING	0.847698	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0.917671	488	448 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0 89.00
90.00	09000	CLINIC	0.284356	3,906	1,111 90.00
91.00	09100	EMERGENCY	0.101602	1,438,469	146,151 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.357952	860,666	308,077 92.00
93.00	04950	SLEEP LAB	0.226973	0	0 93.00
200.00		Total (sum of lines 50-94 and 96-98)		17,207,758	3,084,553 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		17,207,758	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/26/2016 3:21 pm
		Title XVIII	Hospital	PPS
		0	1.00	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		21,621,734	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		7,333,175	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		526,916	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		210.99	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.17	30.00
31.00	Percentage of Medicaid patient days (see instructions)		25.55	31.00
32.00	Sum of lines 30 and 31		29.72	32.00
33.00	Allowable disproportionate share percentage (see instructions)		13.73	33.00
34.00	Disproportionate share adjustment (see instructions)		993,877	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/26/2016 3:21 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			1.00	2.00	
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.00000000	0.00000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,892,804	1,531,132	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,415,713	384,875	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,800,588		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		32,276,290		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		32,276,290		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,484,268		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		73,000		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		48,813		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		25,086		58.00
59.00	Total (sum of amounts on lines 49 through 58)		34,907,457		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		34,907,457		61.00
62.00	Deductibles billed to program beneficiaries		2,892,724		62.00
63.00	Coinurance billed to program beneficiaries		129,245		63.00
64.00	Allowable bad debts (see instructions)		871,684		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		566,595		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		482,572		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		32,452,083		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 PER PS&R		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)		52,848		70.93
70.94	HRR adjustment amount (see instructions)		-119,196		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/26/2016 3:21 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		32,385,735		71.00
71.01	Sequestration adjustment (see instructions)		647,715		71.01
72.00	Interim payments		31,035,616		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)		702,404		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		321,170		75.00
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/26/2016 3:21 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		176,877	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		14,838,498	2.00
3.00	PPS payments		14,169,451	3.00
4.00	Outlier payment (see instructions)		22,904	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.778	5.00
6.00	Line 2 times line 5		11,544,351	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		31,036	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		176,877	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		499,545	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		499,545	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		499,545	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		322,668	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)		176,877	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)		14,223,391	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		73,134	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,912,691	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		11,414,443	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)		11,414,443	30.00
31.00	Primary payer payments		1,620	31.00
32.00	Subtotal (line 30 minus line 31)		11,412,823	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		766,307	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		498,100	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		519,570	36.00
37.00	Subtotal (see instructions)		11,910,923	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)		11,910,923	40.00
40.01	Sequestration adjustment (see instructions)		238,218	40.01
41.00	Interim payments		11,485,332	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		187,373	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/26/2016 3:21 pm
		Component CCN: 145599	Title XVIII	Skilled Nursing Facility PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	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)		0	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		0	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)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R			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)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140250

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/26/2016 3:21 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		31,214,052		11,657,554	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	08/28/2015	178,436	08/28/2015	172,222	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)		-178,436		-172,222	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		31,035,616		11,485,332	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		702,404		187,373	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		31,738,020		11,672,705	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: 140250  
Component CCN: 145599

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/26/2016 3:21 pm

Title XVIII

Skilled Nursing  
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2,768,911		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)		2,768,911		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		29,400		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,798,311		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: 140250

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

Worksheet E-1  
Part II  
Date/Time Prepared:  
5/26/2016 3:21 pm

Title XVIII		Hospital	PPS
			1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	10,260	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	15,748	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	7,206	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	40,554	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	869,794,174	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	11,867,352	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)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140250 Component CCN: 145599	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VI Date/Time Prepared: 5/26/2016 3:21 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		2,989,195	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,989,195	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		163,776	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		30,000	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		2,855,419	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (see instructions)		2,855,419	15.00
15.01	Sequestration adjustment (see instructions)		57,108	15.01
16.00	Interim payments		2,768,911	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)		29,400	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 140250

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

Worksheet G

Date/Time Prepared:  
5/26/2016 3:21 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	120,549,000	0	0	0	1.00
2.00	Temporary investments	81,893,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	518,635,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	172,222,000	0	0	0	9.00
10.00	Due from other funds	28,283,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	921,582,000	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	121,391,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	2,664,476,000	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,309,817,000	0	0	0	23.00
24.00	Accumulated depreciation	-2,158,727,000	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	1,936,957,000	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	4,096,861,000	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	352,448,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,449,309,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	7,307,848,000	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	314,213,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	344,980,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	70,871,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	460,696,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,190,760,000	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,501,836,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	936,798,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,438,634,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,629,394,000	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	3,678,454,000	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	3,678,454,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	7,307,848,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140250

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

Worksheet G-1

Date/Time Prepared:  
5/26/2016 3:21 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		3,741,789,000		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		16,060,947			2.00
3.00	Total (sum of line 1 and line 2)		3,757,849,947		0	3.00
4.00	SYSTEM ADJUSTMENT	-79,395,947		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		-79,395,947		0	10.00
11.00	Subtotal (line 3 plus line 10)		3,678,454,000		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,678,454,000		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	SYSTEM ADJUSTMENT		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	Deductions (debit adjustments) (specify)		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: 140250

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/26/2016 3:21 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	86,796,466		86,796,466	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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	8,689,842		8,689,842	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)	95,486,308		95,486,308	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	23,583,571		23,583,571	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	23,583,571		23,583,571	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	119,069,879		119,069,879	17.00
18.00	Ancillary services	279,037,232	301,513,293	580,550,525	18.00
19.00	Outpatient services	36,661,044	135,280,616	171,941,660	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON RE - ACCRUAL	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	434,768,155	436,793,909	871,562,064	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		210,197,028		29.00
30.00		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)		210,197,028		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140250

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

Worksheet G-3

Date/Time Prepared:  
5/26/2016 3:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	871,562,064	1.00
2.00	Less contractual allowances and discounts on patients' accounts	647,497,144	2.00
3.00	Net patient revenues (line 1 minus line 2)	224,064,920	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	210,197,028	4.00
5.00	Net income from service to patients (line 3 minus line 4)	13,867,892	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	25,134	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	591,773	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	3,003	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	16,186	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	17,608	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	476,887	22.00
23.00	Governmental appropriations	0	23.00
24.00	<b>OTHER OPERATING INCOME</b>	1,062,464	24.00
25.00	Total other income (sum of lines 6-24)	2,193,055	25.00
26.00	Total (line 5 plus line 25)	16,060,947	26.00
27.00	<b>CORPORATE EXPENSES</b>	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)	16,060,947	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

Provider CCN: 140250

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

Worksheet I-5  
Date/Time Prepared:  
5/26/2016 3:21 pm

		1.00	2.00	
<b>PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B</b>				
1.00	Total expenses related to care of program beneficiaries (see instructions)	0		1.00
2.00	Total payment due (from Wkst. 1-4, col. 6, line 11) (see instructions)	0	0	2.00
2.01	Total payment due (from Wkst. 1-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	0	0	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	0	0	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012	0	0	5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013	0	0	5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014	0	0	5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Total bad debts (sum of line 5 through line 5.04)	0	0	5.05
6.00	Allowable bad debts (see instructions)	0		6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	8.00
9.00	Program payment (see instructions)	0	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
<b>PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE</b>				
12.00	Total allowable expenses (see instructions)	0		12.00
13.00	Total composite costs (from Wkst. 1-4, col. 2, line 11)	0		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	0.000000		14.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140250	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/26/2016 3:21 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		2,316,873	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		23,749	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)		112.24	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		4.17	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		25.55	8.00
9.00	Sum of lines 7 and 8		29.72	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.20	10.00
11.00	Disproportionate share adjustment (see instructions)		143,646	11.00
12.00	Total prospective capital payments (see instructions)		2,484,268	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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