

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).
 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY
 Provider CCN: 140292
 Period: From 01/01/2015 To 12/31/2015
 Worksheet 5
 Parts I-III
 Date/Time Prepared: 5/19/2016 11:41 am
 FORM APPROVED
 OMB NO. 0938-0050

PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.
 Contractor use only 5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended
 6. Date Received:
 7. Contractor No.
 8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.
 Date: 5/19/2016 Time: 11:41 am

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 ADVENTIST GLENOAKS HOSPITAL (140292) 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.

Encryption Information

ECR: Date: 5/19/2016 Time: 11:41 am
 oxU2qfww3mPYTYMDzDbxAV3cwssjJ0
 hNAQQOVk2mvp4wMr0usZNSsGxayWUS
 W3Rp1GHVF30xjxvR
 PI: Date: 5/19/2016 Time: 11:41 am
 5twc6virqWU.uAaa:gSpZKQ1eTw210
 6x1Ms0fRzqd71vljesisyowUL:AhGx
 Rvxe0xyITm0EgOt4

(Signed)

Officer or Administrator of Provider(s)

CFO

Title

Date

5/23/2016

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	437,314	-34,700	0	0	1.00
2.00 Subprovider - IPF	0	27,147	-584		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	464,461	-35,284	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-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140292	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/19/2016 11:40 am
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		1.00	2.00	3.00	4.00						
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 701 WINTHROP AVENUE	PO Box:							1.00		
2.00	City: GLENDALE HEIGHTS	State: IL		Zip Code: 60139-		County: DUPAGE			2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
							V	XVIII	XIX		
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital	ADVENTIST GLENOAKS HOSPITAL	140292	16974	1	11/23/1982	N	P	O	3.00	
4.00	Subprovider - IPF	GLEN OAKS MED CTR PSYCH UNIT	145292	16974	4	01/01/1984	N	P	T	4.00	
5.00	Subprovider - IRF									5.00	
6.00	Subprovider - (Other)									6.00	
7.00	Swing Beds - SNF									7.00	
8.00	Swing Beds - NF									8.00	
9.00	Hospital-Based SNF									9.00	
10.00	Hospital-Based NF									10.00	
11.00	Hospital-Based OLTC									11.00	
12.00	Hospital-Based HHA									12.00	
13.00	Separately Certified ASC									13.00	
14.00	Hospital-Based Hospice									14.00	
15.00	Hospital-Based Health Clinic - RHC									15.00	
16.00	Hospital-Based Health Clinic - FQHC									16.00	
17.00	Hospital-Based (CMHC) I									17.00	
18.00	Renal Dialysis									18.00	
19.00	Other									19.00	
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2015	12/31/2015		20.00		
21.00	Type of Control (see instructions)					1		21.00			
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3		N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3,906	887	0	17	5,775	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: 140292	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/19/2016 11:40 am		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	Y		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete wkst. L, Pt. III and wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete wkst. D-2, Pt. I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	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: 140292

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

Worksheet S-2
Part I
Date/Time Prepared:
5/19/2016 11:40 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 140292 Period: From 01/01/2015 To 12/31/2015 Worksheet S-2 Part I Date/Time Prepared: 5/19/2016 11:40 am

	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	1.00	2.00	3.00	

66.00 **Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010**
 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)

	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)

	1.00	2.00	3.00	
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70.00 **Inpatient Psychiatric Facility PPS**
 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.

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)

75.00 **Inpatient Rehabilitation Facility PPS**
 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.

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)

	1.00			
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80.00 **Long Term Care Hospital PPS**
 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.

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.

85.00 **TEFRA Providers**
 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.

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.

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.

	V	XIX	
	1.00	2.00	

Title V and XIX Services

90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.

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.

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.

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.

94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.

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		V 1.00	XIX 2.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
Rural Providers					
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete wkst. D-2, Pt. II.				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(C). Enter "Y" for yes or "N" for no.	N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					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
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		118.00
			Premiums	Losses	Insurance
			1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	640,907		0	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		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N		N
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140292	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/19/2016 11:40 am				
		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		HF8013	140.00			
		1.00		2.00				
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: ADVENTIST HEALTH SYSTEM	Contractor's Name: FIRST COAST SERVICE OPTIONS		Contractor's Number: 09001	141.00			
142.00	Street: 900 HOPE WAY	PO Box:			142.00			
143.00	City: ALTAMONTE SPRINGS	State: FL	Zip Code:	32714	143.00			
				1.00				
144.00	Are provider based physicians' costs included in worksheet A?	Y			144.00			
		1.00		2.00				
145.00	If costs for renal services are claimed on wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y			145.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00			
				1.00				
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N			147.00			
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N			148.00			
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N			149.00			
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	157.00		
158.00	SUBPROVIDER					158.00		
159.00	SNF	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00		
161.00	CMHC		N	N	N	161.00		
					1.00			
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00		
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y		167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							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
						Beginning	Ending	
						1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2014			09/30/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140292	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/19/2016 11:40 am
				1.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N 171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140292	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/19/2016 11:40 am
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N	
			1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		Y	15.00
		Part A		Part B
Description		Y/N	Date	Y/N
0		1.00	2.00	3.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/01/2016	Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N

	Description	Part A		Part B		
		Y/N	Date	Y/N		
	0	1.00	2.00		3.00	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N			N	21.00
						1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
Interest Expense						
28.00	were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
Purchased Services						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
Provider-Based Physicians						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
		Y/N	Date			
		1.00	2.00			
Home Office Costs						
36.00	were home office costs claimed on the cost report?		Y			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N			40.00
		1.00	2.00			
Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MIKE		THOMPSON		41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVENTIST HEALTH SYSTEM				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	SUNBELT 407-357-2338		MIKE.THOMPSON3@AHSS.ORG		43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		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)	04/01/2016	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	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	117	42,705	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)		117	42,705	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		127	46,355	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	16	5,840		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		143				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

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,504	3,266	21,880			1.00
2.00 HMO and other (see instructions)	1,041	6,679				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,504	3,266	21,880			7.00
8.00 INTENSIVE CARE UNIT	1,048	176	2,309			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		434	697			13.00
14.00 Total (see instructions)	7,552	3,876	24,886	0.00	523.81	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	3,022	0	4,280	0.00	24.39	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	1	40			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	548.20	27.00
28.00 Observation Bed Days		398	4,076			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	30	62			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

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
			11.00	12.00			13.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	1,362	1,032	4,827	1.00
2.00 HMO and other (see instructions)				238	1,471		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		1,362	1,032	4,827	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0		227	512	2,719	16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140292

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

Worksheet S-3
Part II
Date/Time Prepared:
5/19/2016 11:40 am

	Worksheet A Line Number	Amount Reported	Reclassificati 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	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	35,538,294	3,161,930	38,700,224	1,246,533.00	31.05 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician-Part B		251,280	0	251,280	3,621.00	69.40 5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office personnel		628,659	0	628,659	8,322.00	75.54 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		6,279,009	-364,992	5,914,017	198,399.00	29.81 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,035,855	0	1,035,855	19,820.00	52.26 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		260,453	0	260,453	1,831.00	142.25 13.00
14.00	Home office salaries & wage-related costs		4,336,148	0	4,336,148	57,402.00	75.54 14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
WAGE-RELATED COSTS							
17.00	wage-related costs (core) (see instructions)		6,811,561	0	6,811,561		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		1,322,083	0	1,322,083		
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		34,886	0	34,886		
24.00	wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	298,730	105,545	404,275	11,340.00	35.65 26.00
27.00	Administrative & General	5.00	2,601,887	1,993,823	4,595,710	129,284.00	35.55 27.00
28.00	Administrative & General under contract (see inst.)		24,899	0	24,899	143.00	174.12 28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00 29.00
30.00	Operation of Plant	7.00	905,319	89,551	994,870	38,469.00	25.86 30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00 31.00
32.00	Housekeeping	9.00	877,724	0	877,724	62,465.00	14.05 32.00
33.00	Housekeeping under contract (see instructions)		51,282	0	51,282	953.00	53.81 33.00
34.00	Dietary	10.00	945,337	-319,251	626,086	39,103.00	16.01 34.00
35.00	Dietary under contract (see instructions)		129,815	0	129,815	3,440.00	37.74 35.00
36.00	Cafeteria	11.00	0	319,251	319,251	17,987.00	17.75 36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00 37.00
38.00	Nursing Administration	13.00	837,146	360,051	1,197,197	27,270.00	43.90 38.00
39.00	Central Services and Supply	14.00	310,796	44,473	355,269	18,018.00	19.72 39.00
40.00	Pharmacy	15.00	1,410,679	0	1,410,679	32,686.00	43.16 40.00

Provider CCN: 140292
 Period: From 01/01/2015 To 12/31/2015
 Worksheet S-3 Part II
 Date/Time Prepared: 5/19/2016 11:40 am

		Worksheet A Line Number	Amount Reported	Reclassificati 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	251,749	512,410	764,159	32,411.00	23.58	41.00
42.00	Social Service	17.00	749,155	0	749,155	20,379.00	36.76	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140292

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

Worksheet S-3
Part III
Date/Time Prepared:
5/19/2016 11:40 am

	Worksheet A Line Number	Amount Reported	Reclassificati 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	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	34,864,351	3,161,930	38,026,281	1,239,126.00	30.69	1.00
2.00	Excluded area salaries (see instructions)	6,279,009	-364,992	5,914,017	198,399.00	29.81	2.00
3.00	Subtotal salaries (line 1 minus line 2)	28,585,342	3,526,922	32,112,264	1,040,727.00	30.86	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,632,456	0	5,632,456	79,053.00	71.25	4.00
5.00	Subtotal wage-related costs (see inst.)	6,811,561	0	6,811,561	0.00	21.21	5.00
6.00	Total (sum of lines 3 thru 5)	41,029,359	3,526,922	44,556,281	1,119,780.00	39.79	6.00
7.00	Total overhead cost (see instructions)	9,394,518	3,105,853	12,500,371	433,948.00	28.81	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 140292

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

Worksheet S-3
Part IV
Date/Time Prepared:
5/19/2016 11:40 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	1,070,764	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	3,833,484	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	55,113	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)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	401,087	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,616,242	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	52,954	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	138,885	23.00
24.00	Total wage related cost (Sum of lines 1 -23)	8,168,529	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140292

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

Worksheet S-3
Part V
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,035,855	0	1.00
2.00	Hospital	1,035,855	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

		1.00	
Uncompensated and indigent care cost computation			
1.00	Cost to charge ratio (worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.264974	1.00
Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid	33,241,742	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	78,359,970	6.00
7.00	Medicaid cost (line 1 times line 6)	20,763,355	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)			
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
Other state or local government indigent care program (see instructions for each line)			
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	955,341	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	253,141	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)	253,141	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	13,757	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	253,141	19.00
		Uninsured patients	Insured patients
		1.00	2.00
		Total (col. 1 + col. 2)	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	5,335,682	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,413,817	0
22.00	Partial payment by patients approved for charity care	1,456	0
23.00	Cost of charity care (line 21 minus line 22)	1,412,361	0
		1.00	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)	4,034,229	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	533,284	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,500,945	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	927,659	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,340,020	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,593,161	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140292

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

Worksheet A

Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		0	0	1,988,795	1,988,795	1.00
2.00	00200		0	0	2,453,046	2,453,046	2.00
4.00	00400	298,730	5,400,852	5,699,582	579,208	6,278,790	4.00
5.01	01160	0	191,612	191,612	-6,544	185,068	5.01
5.04	00570	741,376	477,941	1,219,317	-130	1,219,187	5.04
5.06	00560	1,860,511	16,767,629	18,628,140	-2,166,403	16,461,737	5.06
7.00	00700	905,319	2,081,927	2,987,246	107,742	3,094,988	7.00
9.00	00900	877,724	726,514	1,604,238	-1,090	1,603,148	9.00
10.00	01000	945,337	643,099	1,588,436	-504,538	1,083,898	10.00
11.00	01100	0	0	0	500,465	500,465	11.00
13.00	01300	837,146	183,080	1,020,226	445,893	1,466,119	13.00
14.00	01400	310,796	99,490	410,286	162,586	572,872	14.00
15.00	01500	1,410,679	2,459,869	3,870,548	-2,405,296	1,465,252	15.00
16.00	01600	251,749	105,486	357,235	662,901	1,020,136	16.00
17.00	01700	749,155	234,970	984,125	-120	984,005	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9,402,999	2,066,175	11,469,174	-1,102,152	10,367,022	30.00
31.00	03100	1,837,098	585,637	2,422,735	-160	2,422,575	31.00
40.00	04000	2,023,884	170,556	2,194,440	-317,905	1,876,535	40.00
43.00	04300	0	9,469	9,469	477,504	486,973	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,401,472	596,380	1,997,852	-13,582	1,984,270	50.00
51.00	05100	243,503	36,581	280,084	0	280,084	51.00
52.00	05200	102	0	102	941,482	941,584	52.00
53.00	05300	43,267	44,180	87,447	-120	87,327	53.00
54.00	05400	842,976	299,635	1,142,611	-1,353	1,141,258	54.00
56.00	05600	153,299	116,839	270,138	-88,354	181,784	56.00
57.00	05700	393,973	49,837	443,810	0	443,810	57.00
58.00	05800	162,926	20,904	183,830	-120	183,710	58.00
59.00	05900	550,342	458,968	1,009,310	-2,520	1,006,790	59.00
60.00	06000	1,386,576	1,139,404	2,525,980	31,785	2,557,765	60.00
65.00	06500	661,869	212,541	874,410	-16,280	858,130	65.00
66.00	06600	0	1,107,803	1,107,803	-126,634	981,169	66.00
67.00	06700	129	39,334	39,463	0	39,463	67.00
68.00	06800	0	15,800	15,800	0	15,800	68.00
69.00	06900	344,842	156,106	500,948	-667	500,281	69.00
70.00	07000	12,218	664	12,882	0	12,882	70.00
71.00	07100	0	853,244	853,244	147,938	1,001,182	71.00
72.00	07200	0	2,277,424	2,277,424	-57,021	2,220,403	72.00
73.00	07300	0	65,468	65,468	2,199,496	2,264,964	73.00
74.00	07400	0	189,826	189,826	0	189,826	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03060	167,169	403,035	570,204	0	570,204	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	234,187	313,292	547,479	-28,096	519,383	90.00
91.00	09100	2,231,816	1,917,365	4,149,181	-2,474	4,146,707	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		3,575,278	3,575,278	-3,857,282	-282,004	113.00
118.00		31,283,169	46,094,214	77,377,383	0	77,377,383	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	22,811	12,520	35,331	0	35,331	190.00
192.00	19200	0	3,959,191	3,959,191	0	3,959,191	192.00
192.03	19203	148,039	380,609	528,648	0	528,648	192.03
194.00	07950	94,664	16,557	111,221	0	111,221	194.00
194.01	07951	108,374	355,990	464,364	0	464,364	194.01
194.03	07953	3,881,237	1,309,026	5,190,263	0	5,190,263	194.03
200.00		35,538,294	52,128,107	87,666,401	0	87,666,401	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140292

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

Worksheet A

Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-171,377	1,817,418	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	224,704	2,677,750	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-51,186	6,227,604	4.00
5.01	01160	COMMUNICATIONS	-14,178	170,890	5.01
5.04	00570	ADMITTING	-257	1,218,930	5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	-4,711,950	11,749,787	5.06
7.00	00700	OPERATION OF PLANT	-18,528	3,076,460	7.00
9.00	00900	HOUSEKEEPING	471	1,603,619	9.00
10.00	01000	DIETARY	-126,074	957,824	10.00
11.00	01100	CAFETERIA	0	500,465	11.00
13.00	01300	NURSING ADMINISTRATION	-3,356	1,462,763	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	572,872	14.00
15.00	01500	PHARMACY	-13,866	1,451,386	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,768	1,024,904	16.00
17.00	01700	SOCIAL SERVICE	-23,625	960,380	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-750,824	9,616,198	30.00
31.00	03100	INTENSIVE CARE UNIT	-53,981	2,368,594	31.00
40.00	04000	SUBPROVIDER - IPF	0	1,876,535	40.00
43.00	04300	NURSERY	0	486,973	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,984,270	50.00
51.00	05100	RECOVERY ROOM	0	280,084	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	941,584	52.00
53.00	05300	ANESTHESIOLOGY	0	87,327	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,255	1,140,003	54.00
56.00	05600	RADIOISOTOPE	0	181,784	56.00
57.00	05700	CT SCAN	0	443,810	57.00
58.00	05800	MRI	0	183,710	58.00
59.00	05900	CARDIAC CATHETERIZATION	-118,137	888,653	59.00
60.00	06000	LABORATORY	-281	2,557,484	60.00
65.00	06500	RESPIRATORY THERAPY	-5,254	852,876	65.00
66.00	06600	PHYSICAL THERAPY	-271	980,898	66.00
67.00	06700	OCCUPATIONAL THERAPY	-127	39,336	67.00
68.00	06800	SPEECH PATHOLOGY	0	15,800	68.00
69.00	06900	ELECTROCARDIOLOGY	-88,673	411,608	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	12,882	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-338	1,000,844	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,220,403	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-399,345	1,865,619	73.00
74.00	07400	RENAL DIALYSIS	0	189,826	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01	03060	WOUND CARE	0	570,204	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-281,509	237,874	90.00
91.00	09100	EMERGENCY	-1,493,731	2,652,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	282,004	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,816,176	69,561,207	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	35,331	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,959,191	192.00
192.03	19203	OP PHARMACY	0	528,648	192.03
194.00	07950	FOUNDATION	0	111,221	194.00
194.01	07951	MARKETING	0	464,364	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	5,190,263	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-7,816,176	79,850,225	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	148,175	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
0			0	148,175	
B - CAFETERIA					
1.00	CAFETERIA	11.00	319,251	181,214	1.00
0			319,251	181,214	
C - NURSERY					
1.00	NURSERY	43.00	350,732	126,772	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	678,054	263,428	2.00
0			1,028,786	390,200	
D - RENT AND LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	122,565	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	407,822	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
0			0	530,387	
E - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,137,632	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,821,526	2.00
0			0	2,959,158	
F - PSYCH ASSESSMENTS					
1.00	ADULTS & PEDIATRICS	30.00	364,992	0	1.00
2.00	SUBPROVIDER - IPF	40.00	0	47,707	2.00
0			364,992	47,707	
G - CNO					
1.00	NURSING ADMINISTRATION	13.00	194,761	74,788	1.00
0			194,761	74,788	
H - RECRUITMENT					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	13,950	0	1.00
2.00	NURSING ADMINISTRATION	13.00	1,667	0	2.00
0			15,617	0	
I - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	51,172	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,000	2.00
0			0	54,172	
J - PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	11,999	1.00
0			0	11,999	
K - IMPLANTIBLES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	237	1.00
0			0	237	

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
L - SHARED SERVICES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	91,595	487,733	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	2,188,585	1,747,045	2.00
3.00	OPERATION OF PLANT	7.00	89,551	18,931	3.00
4.00	NURSING ADMINISTRATION	13.00	163,623	13,531	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	44,473	147,772	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	512,410	150,691	6.00
7.00	LABORATORY	60.00	56,077	65,096	7.00
8.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	3,146,313	0	8.00
			6,292,627	2,630,799	
M - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	665,427	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	220,698	2.00
			0	886,125	
N - BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,199,496	1.00
			0	2,199,496	
500.00	Grand Total: Increases		8,216,034	10,114,457	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.	
	6.00	7.00	8.00	9.00	10.00		
A - BILLABLE SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	101	0		1.00
2.00	OPERATING ROOM	50.00	0	1,102	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,149	0		3.00
4.00	RADIOISOTOPE	56.00	0	88,354	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	164	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	0	47	0		6.00
7.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	57,258	0		7.00
	0		0	148,175			
B - CAFETERIA							
1.00	DIETARY	10.00	319,251	181,214	0		1.00
	0		319,251	181,214			
C - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	1,028,786	390,200	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,028,786	390,200			
D - RENT AND LEASES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	120	10		1.00
2.00	COMMUNICATIONS	5.01	0	6,544	10		2.00
3.00	ADMITTING	5.04	0	130	0		3.00
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	1,199	0		4.00
5.00	OPERATION OF PLANT	7.00	0	740	0		5.00
6.00	HOUSEKEEPING	9.00	0	1,090	0		6.00
7.00	DIETARY	10.00	0	4,073	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	810	0		8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	29,659	0		9.00
10.00	PHARMACY	15.00	0	205,800	0		10.00
11.00	MEDICAL RECORDS & LIBRARY	16.00	0	200	0		11.00
12.00	SOCIAL SERVICE	17.00	0	120	0		12.00
13.00	ADULTS & PEDIATRICS	30.00	0	350	0		13.00
14.00	INTENSIVE CARE UNIT	31.00	0	160	0		14.00
15.00	SUBPROVIDER - IPF	40.00	0	620	0		15.00
16.00	OPERATING ROOM	50.00	0	12,480	0		16.00
17.00	ANESTHESIOLOGY	53.00	0	120	0		17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	204	0		18.00
19.00	MRI	58.00	0	120	0		19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	2,520	0		20.00
21.00	LABORATORY	60.00	0	89,388	0		21.00
22.00	RESPIRATORY THERAPY	65.00	0	16,280	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	126,470	0		23.00
24.00	ELECTROCARDIOLOGY	69.00	0	620	0		24.00
25.00	CLINIC	90.00	0	28,096	0		25.00
26.00	EMERGENCY	91.00	0	2,474	0		26.00
	0		0	530,387			
E - DEPRECIATION							
1.00	INTEREST EXPENSE	113.00	0	2,959,158	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	2,959,158			
F - PSYCH ASSESSMENTS							
1.00	ADULTS & PEDIATRICS	30.00	0	47,707	0		1.00
2.00	SUBPROVIDER - IPF	40.00	364,992	0	0		2.00
	0		364,992	47,707			
G - CNO							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	194,761	74,788	0		1.00
	0		194,761	74,788			
H - RECRUITMENT							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	13,950	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	1,667	0		2.00
	0		0	15,617			
I - INSURANCE							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	54,172	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	54,172			
J - PROPERTY TAX							
1.00	INTEREST EXPENSE	113.00	0	11,999	13		1.00
	0		0	11,999			
K - IMPLANTIBLES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	237	0		1.00
	0		0	237			

		Decreases					
	Cost Center	Line #	Salary	Other	wkst. A-7	Ref.	
	6.00	7.00	8.00	9.00	10.00		
L - SHARED SERVICES							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	3,146,314	2,630,799	0		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	3,146,313	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
	0		3,146,314	5,777,112			
M - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	886,125	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	886,125			
N - BILLABLE DRUGS							
1.00	PHARMACY	15.00	0	2,199,496	0		1.00
	0		0	2,199,496			
500.00	Grand Total: Decreases		5,054,104	13,276,387			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140292

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

Worksheet A-7
Part I
Date/Time Prepared:
5/19/2016 11:40 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,869,112	0	0	0	1.00
2.00	Land Improvements	78,294	360,042	0	360,042	2.00
3.00	Buildings and Fixtures	26,822,408	7,597	0	7,597	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	7,355,288	588,598	0	588,598	5.00
6.00	Movable Equipment	14,102,660	527,932	0	527,932	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	50,227,762	1,484,169	0	1,484,169	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	50,227,762	1,484,169	0	1,484,169	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,869,112	0			1.00
2.00	Land Improvements	438,336	0			2.00
3.00	Buildings and Fixtures	26,830,005	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	7,943,886	0			5.00
6.00	Movable Equipment	14,630,592	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	51,711,931	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	51,711,931	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140292

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

Worksheet A-7
Part II
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		SUMMARY OF CAPITAL						
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9.00	10.00	11.00	12.00	13.00		
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2								
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00	
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00	
Cost Center Description		SUMMARY OF CAPITAL						
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)					
		14.00	15.00					
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2								
1.00	CAP REL COSTS-BLDG & FIXT	0	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0					2.00
3.00	Total (sum of lines 1-2)	0	0					3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140292

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

Worksheet A-7
Part III
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	37,081,339	0	37,081,339	0.717075	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,630,592	0	14,630,592	0.282925	0	2.00
3.00	Total (sum of lines 1-2)	51,711,931	0	51,711,931	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,213,422	122,565	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,124,227	407,822	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,337,649	530,387	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	418,260	51,172	11,999	0	1,817,418	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	142,701	3,000	0	0	2,677,750	2.00
3.00	Total (sum of lines 1-2)	560,961	54,172	11,999	0	4,495,168	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted		Line #	Wkst. A-7	Ref.
			3.00	4.00			
			5.00				
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-235,168	CAP REL COSTS-BLDG & FIXT		1.00		11 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-77,997	CAP REL COSTS-MVBLE EQUIP		2.00		11 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	-14,178	COMMUNICATIONS		5.01		0 7.00
8.00 Television and radio service (chapter 21)	A	-11,430	OPERATION OF PLANT		7.00		0 8.00
9.00 Parking lot (chapter 21)		0			0.00		0 9.00
10.00 Provider-based physician adjustment	A-8-2	-529,838					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	1,149,022					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		0			0.00		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		0 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00		0 24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00		0 25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT		1.00		0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP		2.00		0 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00		0 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		0 30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00		0 30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00		0 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00		0 32.00
33.00 MISC REVENUE	B	-638	EMPLOYEE BENEFITS DEPARTMENT		4.00		0 33.00
33.01 MISC REVENUE	B	-257	ADMITTING		5.04		0 33.01

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted			Ref.
			Cost Center	Line #	Wkst. A-7	
	1.00	2.00	3.00	4.00	5.00	
33.02 MISC REVENUE	B	-23,124	OTHER ADMINISTRATIVE AND GENERAL	5.06		0 33.02
33.03 MISC REVENUE	B	-7,098	OPERATION OF PLANT	7.00		0 33.03
33.04 MISC REVENUE	B	471	HOUSEKEEPING	9.00		0 33.04
33.05 MISC REVENUE	B	-126,074	DIETARY	10.00		0 33.05
33.06 MISC REVENUE	B	-60	NURSING ADMINISTRATION	13.00		0 33.06
33.07 MISC REVENUE	B	-10,231	MEDICAL RECORDS & LIBRARY	16.00		0 33.07
33.08 MISC REVENUE	B	-276	ADULTS & PEDIATRICS	30.00		0 33.08
33.09 MISC REVENUE	B	-1,255	RADIOLOGY-DIAGNOSTIC	54.00		0 33.09
33.10 MISC REVENUE	B	-150	LABORATORY	60.00		0 33.10
33.11 MISC REVENUE	B	-77	PHYSICAL THERAPY	66.00		0 33.11
33.12 MISC REVENUE	B	-1,200	DRUGS CHARGED TO PATIENTS	73.00		0 33.12
33.13 MISC REVENUE	B	-27,603	CLINIC	90.00		0 33.13
33.14 MISC REVENUE	B	-10,000	EMERGENCY	91.00		0 33.14
33.15 LEAGAL	A	-134,982	OTHER ADMINISTRATIVE AND GENERAL	5.06		0 33.15
33.16 LOBBYING	A	-47,887	OTHER ADMINISTRATIVE AND GENERAL	5.06		0 33.16
33.17 NON ALLOW PHYSICIAN PAYMENTS	A	6,480	OTHER ADMINISTRATIVE AND GENERAL	5.06		0 33.17
33.18 NON ALLOW PHYSICIAN PAYMENTS	A	-433,650	ADULTS & PEDIATRICS	30.00		0 33.18
33.19 NON ALLOW PHYSICIAN PAYMENTS	A	-91,170	CARDIAC CATHETERIZATION	59.00		0 33.19
33.20 NON ALLOW PHYSICIAN PAYMENTS	A	-1,214	CLINIC	90.00		0 33.20
33.21 NON ALLOW PHYSICIAN PAYMENTS	A	-1,483,404	EMERGENCY	91.00		0 33.21
33.22 HOSPICE	A	-131	LABORATORY	60.00		0 33.22
33.23 HOSPICE	A	-5,254	RESPIRATORY THERAPY	65.00		0 33.23
33.24 HOSPICE	A	-194	PHYSICAL THERAPY	66.00		0 33.24
33.25 HOSPICE	A	-127	OCCUPATIONAL THERAPY	67.00		0 33.25
33.26 HOSPICE	A	-338	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		0 33.26
33.27 HOSPICE	A	-42,179	DRUGS CHARGED TO PATIENTS	73.00		0 33.27
33.28 HOSPICE	A	-327	EMERGENCY	91.00		0 33.28
33.29 HOSPICE	A	-316,898	ADULTS & PEDIATRICS	30.00		0 33.29
33.30 RECRUITMENT	A	-7,933	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.30
33.32 PROPERTY TAXES	A	-11,999	CAP REL COSTS-BLDG & FIXT	1.00		11 33.32
35.00 STATE ASSESSMENT	A	-4,246,362	OTHER ADMINISTRATIVE AND GENERAL	5.06		0 35.00
37.00 NON ALLOW COLLECTION FEE	A	-37,633	ELECTROCARDIOLOGY	69.00		0 37.00
38.00 MALPRACTICE	A	-640,907	OTHER ADMINISTRATIVE AND GENERAL	5.06		0 38.00
39.00 SPECIAL EVENTS	A	-1,609	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 39.00
41.00 SPECIAL EVENTS	A	-11,598	OTHER ADMINISTRATIVE AND GENERAL	5.06		0 41.00
42.00 SPECIAL EVENTS	A	-3,296	NURSING ADMINISTRATION	13.00		0 42.00
43.00 NON ALLOW BANK FEES	A	-116	OTHER ADMINISTRATIVE AND GENERAL	5.06		0 43.00
44.00 SELF INSURANCE	A	-236,648	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 44.00
45.00 NON ALLOWABLE INTEREST	A	-139,639	INTEREST EXPENSE	113.00		11 45.00
46.00		0		0.00		0 46.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,816,176				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: 140292

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

Worksheet A-8-1

Date/Time Prepared: 5/19/2016 11:40 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
HOME OFFICE COSTS:					
1.00	5.06	OTHER ADMINISTRATIVE AND GEN	AHS SHARED SERVICES	5,777,113	5,412,822 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	AHS HOME OFFICE	75,790	0 2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	AHS HOME OFFICE	302,701	0 3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	AHS HOME OFFICE	228,358	32,716 3.01
3.02	5.06	OTHER ADMINISTRATIVE AND GEN	AHS HOME OFFICE	4,959,327	4,761,558 3.02
4.00	15.00	PHARMACY	AHS HOME OFFICE	0	13,866 4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	AHS HOME OFFICE	14,999	0 4.01
4.02	31.00	INTENSIVE CARE UNIT	AHS HOME OFFICE	0	53,981 4.02
4.03	73.00	DRUGS CHARGED TO PATIENTS	AHS HOME OFFICE	-355,966	0 4.03
4.04	113.00	INTEREST EXPENSE	AHS HOME OFFICE	1,025,764	604,121 4.04
5.00	TOTALS (sum of lines 1-4).			12,028,086	10,879,064 5.00
Transfer column 6, line 5 to worksheet A-8, column 2, line 12.					

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

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

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

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

6.00	B	AHS CORPORATE	100.00	AHS CORPORATE	0.00	6.00
7.00	B	SHARED SERVICE	0.00	SHARED SERVICE	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: 140292

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

worksheet A-8-1
Date/Time Prepared:
5/19/2016 11:40 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	364,291	0	1.00
2.00	75,790	9	2.00
3.00	302,701	9	3.00
3.01	195,642	0	3.01
3.02	197,769	0	3.02
4.00	-13,866	0	4.00
4.01	14,999	0	4.01
4.02	-53,981	0	4.02
4.03	-355,966	0	4.03
4.04	421,643	0	4.04
5.00	1,149,022		5.00

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

Related Organization(s) and/or Home Office	Type of Business
	6.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	MANAGEMENT SVCS	6.00
7.00	FINANCIAL SVCS	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: 140292

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

Worksheet A-8-2

Date/Time Prepared:
5/19/2016 11:40 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.06	AGGREGATE-OTHER ADMINISTRATIVE AND G	175,514	175,514	0	0	0	1.00
2.00	17.00	AGGREGATE-SOCIAL SERVICE	23,625	23,625	0	0	0	2.00
3.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	26,967	26,967	0	0	0	3.00
4.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	51,040	51,040	0	0	0	4.00
5.00	90.00	AGGREGATE-CLINIC	252,692	252,692	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			529,838	529,838	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	5.06	AGGREGATE-OTHER ADMINISTRATIVE AND G	0	0	0	0	0	1.00
2.00	17.00	AGGREGATE-SOCIAL SERVICE	0	0	0	0	0	2.00
3.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	0	0	0	0	3.00
4.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	90.00	AGGREGATE-CLINIC	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	5.06	AGGREGATE-OTHER ADMINISTRATIVE AND G	0	0	0	175,514		1.00
2.00	17.00	AGGREGATE-SOCIAL SERVICE	0	0	0	23,625		2.00
3.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	0	0	26,967		3.00
4.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	51,040		4.00
5.00	90.00	AGGREGATE-CLINIC	0	0	0	252,692		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	529,838		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140292

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

Worksheet B
Part I
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,817,418	1,817,418			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,677,750		2,677,750		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,227,604	10,280	15,146	6,253,030	4.00
5.01 01160	COMMUNICATIONS	170,890	11,783	17,361	0	200,034 5.01
5.04 00570	ADMITTING	1,218,930	5,949	8,766	121,053	0 5.04
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	11,749,787	41,054	60,489	629,343	144,705 5.06
7.00 00700	OPERATION OF PLANT	3,076,460	526,756	776,109	162,444	0 7.00
9.00 00900	HOUSEKEEPING	1,603,619	13,621	20,068	143,317	0 9.00
10.00 01000	DIETARY	957,824	47,518	70,012	102,229	0 10.00
11.00 01100	CAFETERIA	500,465	27,614	40,686	52,128	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,462,763	6,450	9,504	195,481	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	572,872	54,829	80,784	58,009	0 14.00
15.00 01500	PHARMACY	1,451,386	19,159	28,228	230,338	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,024,904	12,426	18,308	124,773	0 16.00
17.00 01700	SOCIAL SERVICE	960,380	5,525	8,141	122,324	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	9,616,198	336,312	495,516	1,426,945	45,269 30.00
31.00 03100	INTENSIVE CARE UNIT	2,368,594	38,536	56,778	299,965	3,869 31.00
40.00 04000	SUBPROVIDER - IPF	1,876,535	61,485	90,591	270,867	6,191 40.00
43.00 04300	NURSERY	486,973	19,030	28,039	57,268	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,984,270	113,873	167,778	228,835	0 50.00
51.00 05100	RECOVERY ROOM	280,084	7,838	11,549	39,760	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	941,584	36,801	54,222	110,731	0 52.00
53.00 05300	ANESTHESIOLOGY	87,327	2,133	3,143	7,065	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,140,003	48,880	72,019	137,643	0 54.00
56.00 05600	RADIOISOTOPE	181,784	13,351	19,671	25,031	0 56.00
57.00 05700	CT SCAN	443,810	34,296	50,530	64,329	0 57.00
58.00 05800	MRI	183,710	16,794	24,745	26,603	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	888,653	20,495	30,197	89,861	0 59.00
60.00 06000	LABORATORY	2,557,484	32,098	47,293	235,559	0 60.00
65.00 06500	RESPIRATORY THERAPY	852,876	4,510	6,645	108,071	0 65.00
66.00 06600	PHYSICAL THERAPY	980,898	16,370	24,120	0	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	39,336	1,079	1,590	21	0 67.00
68.00 06800	SPEECH PATHOLOGY	15,800	707	1,041	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	411,608	26,457	38,982	56,306	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	12,882	3,624	5,339	1,995	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,000,844	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	2,220,403	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,865,619	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	189,826	0	0	0	0 74.00
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0 76.00
76.01 03060	WOUND CARE	570,204	18,786	27,679	27,296	0 76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	237,874	11,243	16,566	38,239	0 90.00
91.00 09100	EMERGENCY	2,652,976	100,201	147,634	364,415	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	69,561,207	1,747,863	2,575,269	5,558,244	200,034 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35,331	3,534	5,206	3,725	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	3,959,191	0	0	0	0 192.00
192.03 19203	OP PHARMACY	528,648	1,940	2,859	24,172	0 192.03
194.00 07950	FOUNDATION	111,221	2,300	3,389	15,457	0 194.00
194.01 07951	MARKETING	464,364	3,058	4,506	17,696	0 194.01
194.03 07953	THERAPEUTIC DAY SCHOOL	5,190,263	58,723	86,521	633,736	0 194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118-201)	79,850,225	1,817,418	2,677,750	6,253,030	200,034 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140292

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

Worksheet B
Part I
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		ADMITTING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	HOUSEKEEPING	
		5.04	5A.04	5.06	7.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.04	00570	ADMITTING	1,354,698				5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	0	12,625,378	12,625,378		5.06
7.00	00700	OPERATION OF PLANT	0	4,541,769	852,981	5,394,750	7.00
9.00	00900	HOUSEKEEPING	0	1,780,625	334,416	60,150	2,175,191
10.00	01000	DIETARY	0	1,177,583	221,160	209,845	85,565
11.00	01100	CAFETERIA	0	620,893	116,609	121,946	49,724
13.00	01300	NURSING ADMINISTRATION	0	1,674,198	314,428	28,486	11,615
14.00	01400	CENTRAL SERVICES & SUPPLY	0	766,494	143,954	242,134	98,730
15.00	01500	PHARMACY	0	1,729,111	324,741	84,608	34,499
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,180,411	221,691	54,873	22,375
17.00	01700	SOCIAL SERVICE	0	1,096,370	205,907	24,401	9,949
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	192,706	12,112,946	2,274,922	1,485,204	605,592
31.00	03100	INTENSIVE CARE UNIT	28,287	2,796,029	525,117	170,180	69,391
40.00	04000	SUBPROVIDER - IPF	35,327	2,340,996	439,658	271,528	110,716
43.00	04300	NURSERY	3,587	594,897	111,726	84,040	34,268
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	81,405	2,576,161	483,824	502,880	205,050
51.00	05100	RECOVERY ROOM	13,391	352,622	66,225	34,615	14,114
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,987	1,150,325	216,040	162,519	66,268
53.00	05300	ANESTHESIOLOGY	20,046	119,714	22,483	9,420	3,841
54.00	05400	RADIOLOGY-DIAGNOSTIC	79,763	1,478,308	277,638	215,860	88,017
56.00	05600	RADIOISOTOPE	17,768	257,605	48,380	58,959	24,041
57.00	05700	CT SCAN	122,333	715,298	134,339	151,454	61,756
58.00	05800	MRI	25,091	276,943	52,012	74,167	30,242
59.00	05900	CARDIAC CATHETERIZATION	32,469	1,061,675	199,391	90,509	36,905
60.00	06000	LABORATORY	181,218	3,053,652	573,500	141,751	57,799
65.00	06500	RESPIRATORY THERAPY	37,356	1,009,458	189,584	19,918	8,121
66.00	06600	PHYSICAL THERAPY	20,567	1,041,955	195,687	72,294	29,478
67.00	06700	OCCUPATIONAL THERAPY	1,334	43,360	8,143	4,767	1,944
68.00	06800	SPEECH PATHOLOGY	1,350	18,898	3,549	3,121	1,273
69.00	06900	ELECTROCARDIOLOGY	43,931	577,284	108,419	116,839	47,641
70.00	07000	ELECTROENCEPHALOGRAPHY	1,101	24,941	4,684	16,002	6,525
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,600	1,026,444	192,774	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,508	2,265,911	425,556	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	117,908	1,983,527	372,522	0	0
74.00	07400	RENAL DIALYSIS	3,294	193,120	36,269	0	0
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01	03060	WOUND CARE	7,443	651,408	122,340	82,962	33,828
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	9,526	313,448	58,868	49,652	20,246
91.00	09100	EMERGENCY	199,402	3,464,628	650,685	442,502	180,431
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,354,698	68,694,385	10,530,222	5,087,586	2,049,944
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	47,796	8,976	15,605	6,363
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,959,191	743,568	0	0
192.03	19203	OP PHARMACY	0	557,619	104,725	8,569	3,494
194.00	07950	FOUNDATION	0	132,367	24,860	10,157	4,142
194.01	07951	MARKETING	0	489,624	91,955	13,505	5,507
194.03	07953	THERAPEUTIC DAY SCHOOL	0	5,969,243	1,121,072	259,328	105,741
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,354,698	79,850,225	12,625,378	5,394,750	2,175,191

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140292

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

Worksheet B
Part I
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.04	00570						5.04
5.06	00560						5.06
7.00	00700						7.00
9.00	00900						9.00
10.00	01000	1,694,153					10.00
11.00	01100	0	909,172				11.00
13.00	01300	0	27,636	2,056,363			13.00
14.00	01400	0	18,916	0	1,270,228		14.00
15.00	01500	0	38,844	0	8,558	2,220,361	15.00
16.00	01600	0	16,138	0	0	0	16.00
17.00	01700	0	23,981	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,302,053	321,377	1,070,778	100,755	109	30.00
31.00	03100	137,403	57,422	191,319	52,216	0	31.00
40.00	04000	254,697	59,283	197,521	10,629	0	40.00
43.00	04300	0	12,160	40,515	2,681	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	45,434	151,377	96,210	824	50.00
51.00	05100	0	5,905	19,676	1,632	0	51.00
52.00	05200	0	23,512	78,337	0	0	52.00
53.00	05300	0	2,353	7,841	8,042	0	53.00
54.00	05400	0	28,019	0	4,134	2,184	54.00
56.00	05600	0	4,006	0	26,930	302	56.00
57.00	05700	0	11,858	0	4,671	360	57.00
58.00	05800	0	4,514	0	693	120	58.00
59.00	05900	0	13,106	0	15,902	0	59.00
60.00	06000	0	53,551	0	8,958	0	60.00
65.00	06500	0	25,035	0	18,339	0	65.00
66.00	06600	0	0	0	999	528	66.00
67.00	06700	0	4	0	10	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	12,387	0	1,758	14,824	69.00
70.00	07000	0	544	0	123	0	70.00
71.00	07100	0	0	0	237,143	0	71.00
72.00	07200	0	0	0	568,609	0	72.00
73.00	07300	0	0	0	0	2,190,519	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03060	0	6,821	0	6,743	829	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	8,606	28,672	4,136	1,191	90.00
91.00	09100	0	81,135	270,327	90,357	8,571	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,694,153	902,547	2,056,363	1,270,228	2,220,361	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	985	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.03	19203	0	0	0	0	0	192.03
194.00	07950	0	2,142	0	0	0	194.00
194.01	07951	0	3,498	0	0	0	194.01
194.03	07953	0	0	0	0	0	194.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,694,153	909,172	2,056,363	1,270,228	2,220,361	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140292

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

Worksheet B
Part I
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.04	00570	ADMITTING					5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,495,488				16.00
17.00	01700	SOCIAL SERVICE	0	1,360,608			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	212,702	1,045,705	20,532,143	0	20,532,143
31.00	03100	INTENSIVE CARE UNIT	31,222	110,351	4,140,650	0	4,140,650
40.00	04000	SUBPROVIDER - IPF	38,992	204,552	3,928,572	0	3,928,572
43.00	04300	NURSERY	3,960	0	884,247	0	884,247
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	89,852	0	4,151,612	0	4,151,612
51.00	05100	RECOVERY ROOM	14,780	0	509,569	0	509,569
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,712	0	1,704,713	0	1,704,713
53.00	05300	ANESTHESIOLOGY	22,126	0	195,820	0	195,820
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,040	0	2,182,200	0	2,182,200
56.00	05600	RADIOISOTOPE	19,612	0	439,835	0	439,835
57.00	05700	CT SCAN	135,026	0	1,214,762	0	1,214,762
58.00	05800	MRI	27,694	0	466,385	0	466,385
59.00	05900	CARDIAC CATHETERIZATION	35,838	0	1,453,326	0	1,453,326
60.00	06000	LABORATORY	200,021	0	4,089,232	0	4,089,232
65.00	06500	RESPIRATORY THERAPY	41,232	0	1,311,687	0	1,311,687
66.00	06600	PHYSICAL THERAPY	22,701	0	1,363,642	0	1,363,642
67.00	06700	OCCUPATIONAL THERAPY	1,473	0	59,701	0	59,701
68.00	06800	SPEECH PATHOLOGY	1,490	0	28,331	0	28,331
69.00	06900	ELECTROCARDIOLOGY	48,490	0	927,642	0	927,642
70.00	07000	ELECTROENCEPHALOGRAPHY	1,216	0	54,035	0	54,035
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,256	0	1,484,617	0	1,484,617
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	50,230	0	3,310,306	0	3,310,306
73.00	07300	DRUGS CHARGED TO PATIENTS	130,142	0	4,676,710	0	4,676,710
74.00	07400	RENAL DIALYSIS	3,636	0	233,025	0	233,025
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01	03060	WOUND CARE	8,215	0	913,146	0	913,146
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	10,515	0	495,334	0	495,334
91.00	09100	EMERGENCY	220,315	0	5,408,951	0	5,408,951
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,495,488	1,360,608	66,160,193	0	66,160,193
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	79,725	0	79,725
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,702,759	0	4,702,759
192.03	19203	OP PHARMACY	0	0	674,407	0	674,407
194.00	07950	FOUNDATION	0	0	173,668	0	173,668
194.01	07951	MARKETING	0	0	604,089	0	604,089
194.03	07953	THERAPEUTIC DAY SCHOOL	0	0	7,455,384	0	7,455,384
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,495,488	1,360,608	79,850,225	0	79,850,225

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140292

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

Worksheet B
Part II
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0		15,146	25,426	4.00
5.01 01160	COMMUNICATIONS	0	11,783	17,361	29,144	5.01
5.04 00570	ADMITTING	0	5,949	8,766	14,715	5.04
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	0	41,054	60,489	101,543	5.06
7.00 00700	OPERATION OF PLANT	0	526,756	776,109	1,302,865	7.00
9.00 00900	HOUSEKEEPING	0	13,621	20,068	33,689	9.00
10.00 01000	DIETARY	0	47,518	70,012	117,530	10.00
11.00 01100	CAFETERIA	0	27,614	40,686	68,300	11.00
13.00 01300	NURSING ADMINISTRATION	0	6,450	9,504	15,954	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	54,829	80,784	135,613	14.00
15.00 01500	PHARMACY	0	19,159	28,228	47,387	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	12,426	18,308	30,734	16.00
17.00 01700	SOCIAL SERVICE	0	5,525	8,141	13,666	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	336,312	495,516	831,828	30.00
31.00 03100	INTENSIVE CARE UNIT	0	38,536	56,778	95,314	31.00
40.00 04000	SUBPROVIDER - IPF	0	61,485	90,591	152,076	40.00
43.00 04300	NURSERY	0	19,030	28,039	47,069	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	113,873	167,778	281,651	50.00
51.00 05100	RECOVERY ROOM	0	7,838	11,549	19,387	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	36,801	54,222	91,023	52.00
53.00 05300	ANESTHESIOLOGY	0	2,133	3,143	5,276	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	48,880	72,019	120,899	54.00
56.00 05600	RADIOISOTOPE	0	13,351	19,671	33,022	56.00
57.00 05700	CT SCAN	0	34,296	50,530	84,826	57.00
58.00 05800	MRI	0	16,794	24,745	41,539	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	20,495	30,197	50,692	59.00
60.00 06000	LABORATORY	0	32,098	47,293	79,391	60.00
65.00 06500	RESPIRATORY THERAPY	0	4,510	6,645	11,155	65.00
66.00 06600	PHYSICAL THERAPY	0	16,370	24,120	40,490	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	1,079	1,590	2,669	67.00
68.00 06800	SPEECH PATHOLOGY	0	707	1,041	1,748	68.00
69.00 06900	ELECTROCARDIOLOGY	0	26,457	38,982	65,439	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	3,624	5,339	8,963	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	76.00
76.01 03060	WOUND CARE	0	18,786	27,679	46,465	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	11,243	16,566	27,809	90.00
91.00 09100	EMERGENCY	0	100,201	147,634	247,835	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0				113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,747,863	2,575,269	4,323,132	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,534	5,206	8,740	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.03 19203	OP PHARMACY	0	1,940	2,859	4,799	192.03
194.00 07950	FOUNDATION	0	2,300	3,389	5,689	194.00
194.01 07951	MARKETING	0	3,058	4,506	7,564	194.01
194.03 07953	THERAPEUTIC DAY SCHOOL	0	58,723	86,521	145,244	194.03
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers				0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,817,418	2,677,750	4,495,168	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140292

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		COMMUNICATIONS	ADMITTING	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	HOUSEKEEPING	
		5.01	5.04	5.06	7.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160	29,144					5.01
5.04	00570	0	15,207				5.04
5.06	00560	21,083	0	125,185			5.06
7.00	00700	0	0	8,457	1,311,983		7.00
9.00	00900	0	0	3,316	14,628	52,216	9.00
10.00	01000	0	0	2,193	51,034	2,054	10.00
11.00	01100	0	0	1,156	29,657	1,194	11.00
13.00	01300	0	0	3,117	6,928	279	13.00
14.00	01400	0	0	1,427	58,886	2,370	14.00
15.00	01500	0	0	3,220	20,576	828	15.00
16.00	01600	0	0	2,198	13,345	537	16.00
17.00	01700	0	0	2,041	5,934	239	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,595	2,166	22,564	361,197	14,536	30.00
31.00	03100	564	318	5,206	41,387	1,666	31.00
40.00	04000	902	397	4,359	66,035	2,658	40.00
43.00	04300	0	40	1,108	20,438	823	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	915	4,797	122,298	4,922	50.00
51.00	05100	0	151	657	8,418	339	51.00
52.00	05200	0	79	2,142	39,524	1,591	52.00
53.00	05300	0	225	223	2,291	92	53.00
54.00	05400	0	897	2,753	52,496	2,113	54.00
56.00	05600	0	200	480	14,339	577	56.00
57.00	05700	0	1,375	1,332	36,833	1,482	57.00
58.00	05800	0	282	516	18,037	726	58.00
59.00	05900	0	365	1,977	22,012	886	59.00
60.00	06000	0	2,037	5,686	34,473	1,387	60.00
65.00	06500	0	420	1,880	4,844	195	65.00
66.00	06600	0	231	1,940	17,582	708	66.00
67.00	06700	0	15	81	1,159	47	67.00
68.00	06800	0	15	35	759	31	68.00
69.00	06900	0	494	1,075	28,415	1,144	69.00
70.00	07000	0	12	46	3,892	157	70.00
71.00	07100	0	288	1,911	0	0	71.00
72.00	07200	0	512	4,219	0	0	72.00
73.00	07300	0	1,326	3,693	0	0	73.00
74.00	07400	0	37	360	0	0	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03060	0	84	1,213	20,176	812	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	107	584	12,075	486	90.00
91.00	09100	0	2,219	6,451	107,615	4,331	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		29,144	15,207	104,413	1,237,283	49,210	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	89	3,795	153	190.00
192.00	19200	0	0	7,372	0	0	192.00
192.03	19203	0	0	1,038	2,084	84	192.03
194.00	07950	0	0	246	2,470	99	194.00
194.01	07951	0	0	912	3,284	132	194.01
194.03	07953	0	0	11,115	63,067	2,538	194.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		29,144	15,207	125,185	1,311,983	52,216	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140292

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.04	00570						5.04
5.06	00560						5.06
7.00	00700						7.00
9.00	00900						9.00
10.00	01000	173,227					10.00
11.00	01100	0	100,519				11.00
13.00	01300	0	3,055	30,128			13.00
14.00	01400	0	2,091	0	200,623		14.00
15.00	01500	0	4,295	0	1,352	78,595	15.00
16.00	01600	0	1,784	0	0	0	16.00
17.00	01700	0	2,651	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	133,135	35,534	15,687	15,913	4	30.00
31.00	03100	14,049	6,349	2,803	8,247	0	31.00
40.00	04000	26,043	6,554	2,894	1,679	0	40.00
43.00	04300	0	1,344	594	423	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	5,023	2,218	15,196	29	50.00
51.00	05100	0	653	288	258	0	51.00
52.00	05200	0	2,599	1,148	0	0	52.00
53.00	05300	0	260	115	1,270	0	53.00
54.00	05400	0	3,098	0	653	77	54.00
56.00	05600	0	443	0	4,253	11	56.00
57.00	05700	0	1,311	0	738	13	57.00
58.00	05800	0	499	0	109	4	58.00
59.00	05900	0	1,449	0	2,512	0	59.00
60.00	06000	0	5,921	0	1,415	0	60.00
65.00	06500	0	2,768	0	2,896	0	65.00
66.00	06600	0	0	0	158	19	66.00
67.00	06700	0	0	0	2	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	1,370	0	278	525	69.00
70.00	07000	0	60	0	19	0	70.00
71.00	07100	0	0	0	37,455	0	71.00
72.00	07200	0	0	0	89,808	0	72.00
73.00	07300	0	0	0	0	77,539	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03060	0	754	0	1,065	29	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	951	420	653	42	90.00
91.00	09100	0	8,970	3,961	14,271	303	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		173,227	99,786	30,128	200,623	78,595	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	109	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.03	19203	0	0	0	0	0	192.03
194.00	07950	0	237	0	0	0	194.00
194.01	07951	0	387	0	0	0	194.01
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		173,227	100,519	30,128	200,623	78,595	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140292

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

Worksheet B
Part II
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.04	00570	ADMITTING					5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
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	49,105				16.00
17.00	01700	SOCIAL SERVICE	0	25,028			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,997	19,235	1,471,190	0	1,471,190
31.00	03100	INTENSIVE CARE UNIT	1,027	2,030	180,180	0	180,180
40.00	04000	SUBPROVIDER - IPF	1,283	3,763	269,745	0	269,745
43.00	04300	NURSERY	130	0	72,202	0	72,202
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,956	0	440,936	0	440,936
51.00	05100	RECOVERY ROOM	486	0	30,799	0	30,799
52.00	05200	DELIVERY ROOM & LABOR ROOM	254	0	138,810	0	138,810
53.00	05300	ANESTHESIOLOGY	728	0	10,509	0	10,509
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,896	0	186,442	0	186,442
56.00	05600	RADIOISOTOPE	645	0	54,072	0	54,072
57.00	05700	CT SCAN	4,441	0	132,613	0	132,613
58.00	05800	MRI	911	0	62,731	0	62,731
59.00	05900	CARDIAC CATHETERIZATION	1,179	0	81,437	0	81,437
60.00	06000	LABORATORY	6,579	0	137,847	0	137,847
65.00	06500	RESPIRATORY THERAPY	1,356	0	25,953	0	25,953
66.00	06600	PHYSICAL THERAPY	747	0	61,875	0	61,875
67.00	06700	OCCUPATIONAL THERAPY	48	0	4,021	0	4,021
68.00	06800	SPEECH PATHOLOGY	49	0	2,637	0	2,637
69.00	06900	ELECTROCARDIOLOGY	1,595	0	100,564	0	100,564
70.00	07000	ELECTROENCEPHALOGRAPHY	40	0	13,197	0	13,197
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	929	0	40,583	0	40,583
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,652	0	96,191	0	96,191
73.00	07300	DRUGS CHARGED TO PATIENTS	4,281	0	86,839	0	86,839
74.00	07400	RENAL DIALYSIS	120	0	517	0	517
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01	03060	WOUND CARE	270	0	70,979	0	70,979
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	346	0	43,629	0	43,629
91.00	09100	EMERGENCY	7,160	0	404,598	0	404,598
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	49,105	25,028	4,221,096	0	4,221,096
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	12,901	0	12,901
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	7,372	0	7,372
192.03	19203	OP PHARMACY	0	0	8,103	0	8,103
194.00	07950	FOUNDATION	0	0	8,804	0	8,804
194.01	07951	MARKETING	0	0	12,351	0	12,351
194.03	07953	THERAPEUTIC DAY SCHOOL	0	0	224,541	0	224,541
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	49,105	25,028	4,495,168	0	4,495,168

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140292

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

Worksheet B-1

Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	ADMITTING (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	141,438				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		141,438			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	800	800	38,295,949		4.00
5.01 01160	COMMUNICATIONS	917	917	0	517	5.01
5.04 00570	ADMITTING	463	463	741,376	0	249,685,843
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	3,195	3,195	3,854,334	374	0
7.00 00700	OPERATION OF PLANT	40,994	40,994	994,870	0	0
9.00 00900	HOUSEKEEPING	1,060	1,060	877,724	0	0
10.00 01000	DIETARY	3,698	3,698	626,086	0	0
10.00 01100	CAFETERIA	2,149	2,149	319,251	0	0
13.00 01300	NURSING ADMINISTRATION	502	502	1,197,197	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	4,267	4,267	355,269	0	0
15.00 01500	PHARMACY	1,491	1,491	1,410,679	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	967	967	764,159	0	0
17.00 01700	SOCIAL SERVICE	430	430	749,155	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	26,173	26,173	8,739,205	117	35,515,378
31.00 03100	INTENSIVE CARE UNIT	2,999	2,999	1,837,098	10	5,213,207
40.00 04000	SUBPROVIDER - IPF	4,785	4,785	1,658,892	16	6,510,619
43.00 04300	NURSERY	1,481	1,481	350,732	0	661,131
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	8,862	8,862	1,401,472	0	15,002,773
51.00 05100	RECOVERY ROOM	610	610	243,503	0	2,467,905
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,864	2,864	678,156	0	1,287,642
53.00 05300	ANESTHESIOLOGY	166	166	43,267	0	3,694,410
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,804	3,804	842,976	0	14,700,207
56.00 05600	RADIOISOTOPE	1,039	1,039	153,299	0	3,274,650
57.00 05700	CT SCAN	2,669	2,669	393,973	0	22,545,640
58.00 05800	MRI	1,307	1,307	162,926	0	4,624,150
59.00 05900	CARDIAC CATHETERIZATION	1,595	1,595	550,342	0	5,984,015
60.00 06000	LABORATORY	2,498	2,498	1,442,653	0	33,398,115
65.00 06500	RESPIRATORY THERAPY	351	351	661,869	0	6,884,619
66.00 06600	PHYSICAL THERAPY	1,274	1,274	0	0	3,790,474
67.00 06700	OCCUPATIONAL THERAPY	84	84	129	0	245,929
68.00 06800	SPEECH PATHOLOGY	55	55	0	0	248,871
69.00 06900	ELECTROCARDIOLOGY	2,059	2,059	344,842	0	8,096,465
70.00 07000	ELECTROENCEPHALOGRAPHY	282	282	12,218	0	203,000
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4,718,025
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	8,387,107
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	21,730,166
74.00 07400	RENAL DIALYSIS	0	0	0	0	607,150
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01 03060	WOUND CARE	1,462	1,462	167,169	0	1,371,692
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	875	875	234,187	0	1,755,657
91.00 09100	EMERGENCY	7,798	7,798	2,231,816	0	36,766,846
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	136,025	136,025	34,040,824	517	249,685,843
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	275	275	22,811	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.03 19203	OP PHARMACY	151	151	148,039	0	0
194.00 07950	FOUNDATION	179	179	94,664	0	0
194.01 07951	MARKETING	238	238	108,374	0	0
194.03 07953	THERAPEUTIC DAY SCHOOL	4,570	4,570	3,881,237	0	0
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)	1,817,418	2,677,750	6,253,030	200,034	1,354,698
203.00	Unit cost multiplier (wkst. B, Part I)	12.849574	18.932324	0.163282	386.912959	0.005426
204.00	Cost to be allocated (per wkst. B, Part II)			25,426	29,144	15,207
205.00	Unit cost multiplier (wkst. B, Part II)			0.000664	56.371373	0.000061

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140292

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

Worksheet B-1

Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5A.06	5.06	7.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.04	00570						5.04
5.06	00560	-12,625,378	67,224,847				5.06
7.00	00700		4,541,769	95,069			7.00
9.00	00900		1,780,625	1,060	94,009		9.00
10.00	01000		1,177,583	3,698	3,698	288,788	10.00
11.00	01100		620,893	2,149	2,149		11.00
13.00	01300		1,674,198	502	502		13.00
14.00	01400		766,494	4,267	4,267		14.00
15.00	01500		1,729,111	1,491	1,491		15.00
16.00	01600		1,180,411	967	967		16.00
17.00	01700		1,096,370	430	430		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000		12,112,946	26,173	26,173	221,950	30.00
31.00	03100		2,796,029	2,999	2,999	23,422	31.00
40.00	04000		2,340,996	4,785	4,785	43,416	40.00
43.00	04300		594,897	1,481	1,481		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000		2,576,161	8,862	8,862		50.00
51.00	05100		352,622	610	610		51.00
52.00	05200		1,150,325	2,864	2,864		52.00
53.00	05300		119,714	166	166		53.00
54.00	05400		1,478,308	3,804	3,804		54.00
56.00	05600		257,605	1,039	1,039		56.00
57.00	05700		715,298	2,669	2,669		57.00
58.00	05800		276,943	1,307	1,307		58.00
59.00	05900		1,061,675	1,595	1,595		59.00
60.00	06000		3,053,652	2,498	2,498		60.00
65.00	06500		1,009,458	351	351		65.00
66.00	06600		1,041,955	1,274	1,274		66.00
67.00	06700		43,360	84	84		67.00
68.00	06800		18,898	55	55		68.00
69.00	06900		577,284	2,059	2,059		69.00
70.00	07000		24,941	282	282		70.00
71.00	07100		1,026,444				71.00
72.00	07200		2,265,911				72.00
73.00	07300		1,983,527				73.00
74.00	07400		193,120				74.00
76.00	03050						76.00
76.01	03060		651,408	1,462	1,462		76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000		313,448	875	875		90.00
91.00	09100		3,464,628	7,798	7,798		91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		-12,625,378	56,069,007	89,656	88,596	288,788	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000		47,796	275	275		190.00
192.00	19200		3,959,191				192.00
192.03	19203		557,619	151	151		192.03
194.00	07950		132,367	179	179		194.00
194.01	07951		489,624	238	238		194.01
194.03	07953		5,969,243	4,570	4,570		194.03
200.00							200.00
201.00							201.00
202.00			12,625,378	5,394,750	2,175,191	1,694,153	202.00
203.00			0.187808	56.745627	23.138114	5.866425	203.00
204.00			125,185	1,311,983	52,216	173,227	204.00
205.00			0.001862	13.800324	0.555436	0.599841	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140292

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

worksheet B-1

Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		CAFETERIA (HOURS WORKED)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.04	00570						5.04
5.06	00560						5.06
7.00	00700						7.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	713,131					11.00
13.00	01300		484,106				13.00
14.00	01400	14,837	0	4,342,645			14.00
15.00	01500	30,468	0	29,259	2,209,245		15.00
16.00	01600	12,658	0	0	0	249,685,843	16.00
17.00	01700	18,810	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	252,081	252,081	344,461	108	35,515,378	30.00
31.00	03100	45,040	45,040	178,514	0	5,213,207	31.00
40.00	04000	46,500	46,500	36,340	0	6,510,619	40.00
43.00	04300	9,538	9,538	9,167	0	661,131	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	35,637	35,637	328,922	820	15,002,773	50.00
51.00	05100	4,632	4,632	5,578	0	2,467,905	51.00
52.00	05200	18,442	18,442	0	0	1,287,642	52.00
53.00	05300	1,846	1,846	27,493	0	3,694,410	53.00
54.00	05400	21,977	0	14,132	2,173	14,700,207	54.00
56.00	05600	3,142	0	92,067	300	3,274,650	56.00
57.00	05700	9,301	0	15,970	358	22,545,640	57.00
58.00	05800	3,541	0	2,368	119	4,624,150	58.00
59.00	05900	10,280	0	54,364	0	5,984,015	59.00
60.00	06000	42,004	0	30,626	0	33,398,115	60.00
65.00	06500	19,637	0	62,696	0	6,884,619	65.00
66.00	06600	0	0	3,417	525	3,790,474	66.00
67.00	06700	3	0	34	0	245,929	67.00
68.00	06800	0	0	0	0	248,871	68.00
69.00	06900	9,716	0	6,009	14,750	8,096,465	69.00
70.00	07000	427	0	419	0	203,000	70.00
71.00	07100	0	0	810,741	0	4,718,025	71.00
72.00	07200	0	0	1,943,961	0	8,387,107	72.00
73.00	07300	0	0	0	2,179,554	21,730,166	73.00
74.00	07400	0	0	0	0	607,150	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03060	5,350	0	23,054	825	1,371,692	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	6,750	6,750	14,141	1,185	1,755,657	90.00
91.00	09100	63,640	63,640	308,912	8,528	36,766,846	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		707,934	484,106	4,342,645	2,209,245	249,685,843	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	773	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.03	19203	0	0	0	0	0	192.03
194.00	07950	1,680	0	0	0	0	194.00
194.01	07951	2,744	0	0	0	0	194.01
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00							201.00
202.00		909,172	2,056,363	1,270,228	2,220,361	1,495,488	202.00
203.00		1.274902	4.247754	0.292501	1.005032	0.005989	203.00
204.00		100,519	30,128	200,623	78,595	49,105	204.00
205.00		0.140954	0.062234	0.046198	0.035576	0.000197	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140292

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

Worksheet B-1

Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		SOCIAL SERVICE	
		(TOTAL PATI ENT DAYS)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	01160 COMMUNICATIONS		5.01
5.04	00570 ADMITTING		5.04
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL		5.06
7.00	00700 OPERATION OF PLANT		7.00
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	288,788	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	221,950	30.00
31.00	03100 INTENSIVE CARE UNIT	23,422	31.00
40.00	04000 SUBPROVIDER - IPF	43,416	40.00
43.00	04300 NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0	50.00
51.00	05100 RECOVERY ROOM	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	54.00
56.00	05600 RADIOISOTOPE	0	56.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MRI	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	65.00
66.00	06600 PHYSICAL THERAPY	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400 RENAL DIALYSIS	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	76.00
76.01	03060 WOUND CARE	0	76.01
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0	90.00
91.00	09100 EMERGENCY	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	288,788	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
192.03	19203 OP PHARMACY	0	192.03
194.00	07950 FOUNDATION	0	194.00
194.01	07951 MARKETING	0	194.01
194.03	07953 THERAPEUTIC DAY SCHOOL	0	194.03
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)	1,360,608	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	4.711442	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	25,028	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.086666	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140292

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

Worksheet C
Part I
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		PPS
				Total Costs	Costs		Total Costs	
					RCE Disallowance			
1.00	2.00	3.00	4.00	5.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,532,143		20,532,143	0	20,532,143	30.00
31.00	03100	INTENSIVE CARE UNIT	4,140,650		4,140,650	0	4,140,650	31.00
40.00	04000	SUBPROVIDER - IPF	3,928,572		3,928,572	0	3,928,572	40.00
43.00	04300	NURSERY	884,247		884,247	0	884,247	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,151,612		4,151,612	0	4,151,612	50.00
51.00	05100	RECOVERY ROOM	509,569		509,569	0	509,569	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,704,713		1,704,713	0	1,704,713	52.00
53.00	05300	ANESTHESIOLOGY	195,820		195,820	0	195,820	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,182,200		2,182,200	0	2,182,200	54.00
56.00	05600	RADIOISOTOPE	439,835		439,835	0	439,835	56.00
57.00	05700	CT SCAN	1,214,762		1,214,762	0	1,214,762	57.00
58.00	05800	MRI	466,385		466,385	0	466,385	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,453,326		1,453,326	0	1,453,326	59.00
60.00	06000	LABORATORY	4,089,232		4,089,232	0	4,089,232	60.00
65.00	06500	RESPIRATORY THERAPY	1,311,687	0	1,311,687	0	1,311,687	65.00
66.00	06600	PHYSICAL THERAPY	1,363,642	0	1,363,642	0	1,363,642	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,701	0	59,701	0	59,701	67.00
68.00	06800	SPEECH PATHOLOGY	28,331	0	28,331	0	28,331	68.00
69.00	06900	ELECTROCARDIOLOGY	927,642		927,642	0	927,642	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	54,035		54,035	0	54,035	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,484,617		1,484,617	0	1,484,617	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,310,306		3,310,306	0	3,310,306	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,676,710		4,676,710	0	4,676,710	73.00
74.00	07400	RENAL DIALYSIS	233,025		233,025	0	233,025	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0		0	0	0	76.00
76.01	03060	WOUND CARE	913,146		913,146	0	913,146	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	495,334		495,334	0	495,334	90.00
91.00	09100	EMERGENCY	5,408,951		5,408,951	0	5,408,951	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,224,279		3,224,279	0	3,224,279	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	69,384,472	0	69,384,472	0	69,384,472	200.00
201.00		Less Observation Beds	3,224,279		3,224,279		3,224,279	201.00
202.00		Total (see instructions)	66,160,193	0	66,160,193	0	66,160,193	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140292

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

Worksheet C
Part I
Date/Time Prepared:
5/19/2016 11:40 am

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	31,079,349		31,079,349		30.00
31.00	03100	INTENSIVE CARE UNIT	5,213,207		5,213,207		31.00
40.00	04000	SUBPROVIDER - IPF	6,510,619		6,510,619		40.00
43.00	04300	NURSERY	661,131		661,131		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,560,740	9,442,033	15,002,773	0.276723	50.00
51.00	05100	RECOVERY ROOM	753,895	1,714,010	2,467,905	0.206478	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,178,581	109,061	1,287,642	1.323903	52.00
53.00	05300	ANESTHESIOLOGY	1,523,825	2,170,585	3,694,410	0.053004	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,243,871	10,456,336	14,700,207	0.148447	54.00
56.00	05600	RADIOISOTOPE	1,044,550	2,230,100	3,274,650	0.134315	56.00
57.00	05700	CT SCAN	7,103,018	15,442,622	22,545,640	0.053880	57.00
58.00	05800	MRI	1,485,500	3,138,650	4,624,150	0.100859	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,374,863	2,609,152	5,984,015	0.242868	59.00
60.00	06000	LABORATORY	19,419,571	13,978,544	33,398,115	0.122439	60.00
65.00	06500	RESPIRATORY THERAPY	6,333,287	551,332	6,884,619	0.190524	65.00
66.00	06600	PHYSICAL THERAPY	625,552	3,164,922	3,790,474	0.359755	66.00
67.00	06700	OCCUPATIONAL THERAPY	220,983	24,946	245,929	0.242757	67.00
68.00	06800	SPEECH PATHOLOGY	225,980	22,891	248,871	0.113838	68.00
69.00	06900	ELECTROCARDIOLOGY	4,290,806	3,805,659	8,096,465	0.114574	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	161,750	41,250	203,000	0.266182	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,098,478	2,619,547	4,718,025	0.314669	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,750,924	4,636,183	8,387,107	0.394690	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,293,308	7,436,858	21,730,166	0.215217	73.00
74.00	07400	RENAL DIALYSIS	607,150	0	607,150	0.383801	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0.000000	76.00
76.01	03060	WOUND CARE	18,180	1,353,512	1,371,692	0.665708	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	14,035	1,741,622	1,755,657	0.282136	90.00
91.00	09100	EMERGENCY	7,946,234	28,820,612	36,766,846	0.147115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	840,794	3,595,235	4,436,029	0.726839	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	130,580,181	119,105,662	249,685,843		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	130,580,181	119,105,662	249,685,843		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140292

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

Worksheet C
Part I
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.276723			50.00
51.00	05100 RECOVERY ROOM	0.206478			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.323903			52.00
53.00	05300 ANESTHESIOLOGY	0.053004			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.148447			54.00
56.00	05600 RADIOISOTOPE	0.134315			56.00
57.00	05700 CT SCAN	0.053880			57.00
58.00	05800 MRI	0.100859			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.242868			59.00
60.00	06000 LABORATORY	0.122439			60.00
65.00	06500 RESPIRATORY THERAPY	0.190524			65.00
66.00	06600 PHYSICAL THERAPY	0.359755			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.242757			67.00
68.00	06800 SPEECH PATHOLOGY	0.113838			68.00
69.00	06900 ELECTROCARDIOLOGY	0.114574			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.266182			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.314669			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.394690			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.215217			73.00
74.00	07400 RENAL DIALYSIS	0.383801			74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000			76.00
76.01	03060 WOUND CARE	0.665708			76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.282136			90.00
91.00	09100 EMERGENCY	0.147115			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.726839			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140292

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

Worksheet C
Part I
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Cost	
				Total Costs	RCE Disallowance	Total Costs			
									1.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	20,532,143		20,532,143		0	20,532,143	30.00
31.00	03100	INTENSIVE CARE UNIT	4,140,650		4,140,650		0	4,140,650	31.00
40.00	04000	SUBPROVIDER - IPF	3,928,572		3,928,572		0	3,928,572	40.00
43.00	04300	NURSERY	884,247		884,247		0	884,247	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	4,151,612		4,151,612		0	4,151,612	50.00
51.00	05100	RECOVERY ROOM	509,569		509,569		0	509,569	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,704,713		1,704,713		0	1,704,713	52.00
53.00	05300	ANESTHESIOLOGY	195,820		195,820		0	195,820	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,182,200		2,182,200		0	2,182,200	54.00
56.00	05600	RADIOISOTOPE	439,835		439,835		0	439,835	56.00
57.00	05700	CT SCAN	1,214,762		1,214,762		0	1,214,762	57.00
58.00	05800	MRI	466,385		466,385		0	466,385	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,453,326		1,453,326		0	1,453,326	59.00
60.00	06000	LABORATORY	4,089,232		4,089,232		0	4,089,232	60.00
65.00	06500	RESPIRATORY THERAPY	1,311,687	0	1,311,687		0	1,311,687	65.00
66.00	06600	PHYSICAL THERAPY	1,363,642	0	1,363,642		0	1,363,642	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,701	0	59,701		0	59,701	67.00
68.00	06800	SPEECH PATHOLOGY	28,331	0	28,331		0	28,331	68.00
69.00	06900	ELECTROCARDIOLOGY	927,642		927,642		0	927,642	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	54,035		54,035		0	54,035	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,484,617		1,484,617		0	1,484,617	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,310,306		3,310,306		0	3,310,306	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,676,710		4,676,710		0	4,676,710	73.00
74.00	07400	RENAL DIALYSIS	233,025		233,025		0	233,025	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0		0		0	0	76.00
76.01	03060	WOUND CARE	913,146		913,146		0	913,146	76.01
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	495,334		495,334		0	495,334	90.00
91.00	09100	EMERGENCY	5,408,951		5,408,951		0	5,408,951	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,224,279		3,224,279		0	3,224,279	92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	69,384,472	0	69,384,472		0	69,384,472	200.00
201.00		Less observation Beds	3,224,279		3,224,279		0	3,224,279	201.00
202.00		Total (see instructions)	66,160,193	0	66,160,193		0	66,160,193	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140292

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

Worksheet C
Part I
Date/Time Prepared:
5/19/2016 11:40 am

		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			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,079,349		31,079,349	30.00
31.00	03100	INTENSIVE CARE UNIT	5,213,207		5,213,207	31.00
40.00	04000	SUBPROVIDER - IPF	6,510,619		6,510,619	40.00
43.00	04300	NURSERY	661,131		661,131	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,560,740	9,442,033	15,002,773	50.00
51.00	05100	RECOVERY ROOM	753,895	1,714,010	2,467,905	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,178,581	109,061	1,287,642	52.00
53.00	05300	ANESTHESIOLOGY	1,523,825	2,170,585	3,694,410	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,243,871	10,456,336	14,700,207	54.00
56.00	05600	RADIOISOTOPE	1,044,550	2,230,100	3,274,650	56.00
57.00	05700	CT SCAN	7,103,018	15,442,622	22,545,640	57.00
58.00	05800	MRI	1,485,500	3,138,650	4,624,150	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,374,863	2,609,152	5,984,015	59.00
60.00	06000	LABORATORY	19,419,571	13,978,544	33,398,115	60.00
65.00	06500	RESPIRATORY THERAPY	6,333,287	551,332	6,884,619	65.00
66.00	06600	PHYSICAL THERAPY	625,552	3,164,922	3,790,474	66.00
67.00	06700	OCCUPATIONAL THERAPY	220,983	24,946	245,929	67.00
68.00	06800	SPEECH PATHOLOGY	225,980	22,891	248,871	68.00
69.00	06900	ELECTROCARDIOLOGY	4,290,806	3,805,659	8,096,465	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	161,750	41,250	203,000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,098,478	2,619,547	4,718,025	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,750,924	4,636,183	8,387,107	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,293,308	7,436,858	21,730,166	73.00
74.00	07400	RENAL DIALYSIS	607,150	0	607,150	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	76.00
76.01	03060	WOUND CARE	18,180	1,353,512	1,371,692	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	14,035	1,741,622	1,755,657	90.00
91.00	09100	EMERGENCY	7,946,234	28,820,612	36,766,846	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	840,794	3,595,235	4,436,029	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	130,580,181	119,105,662	249,685,843	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	130,580,181	119,105,662	249,685,843	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140292

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

worksheet C
Part I
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MRI	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000			76.00
76.01	03060 WOUND CARE	0.000000			76.01
OUTPATIENT SERVICE COST CENTERS					
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
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140292

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

Worksheet D
Part I
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,471,190	0	1,471,190	25,956	56.68	30.00	
31.00	INTENSIVE CARE UNIT	180,180		180,180	2,309	78.03	31.00	
40.00	SUBPROVIDER - IPF	269,745	0	269,745	4,280	63.02	40.00	
43.00	NURSERY	72,202		72,202	697	103.59	43.00	
200.00	Total (lines 30-199)	1,993,317		1,993,317	33,242		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	6,504	368,647					30.00
31.00	INTENSIVE CARE UNIT	1,048	81,775					31.00
40.00	SUBPROVIDER - IPF	3,022	190,446					40.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30-199)	10,574	640,868					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140292

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

Worksheet D
Part II
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	440,936	15,002,773	0.029390	1,631,452	47,948	50.00
51.00	05100 RECOVERY ROOM	30,799	2,467,905	0.012480	241,157	3,010	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	138,810	1,287,642	0.107802	5,638	608	52.00
53.00	05300 ANESTHESIOLOGY	10,509	3,694,410	0.002845	434,109	1,235	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	186,442	14,700,207	0.012683	1,793,922	22,752	54.00
56.00	05600 RADIOISOTOPE	54,072	3,274,650	0.016512	414,551	6,845	56.00
57.00	05700 CT SCAN	132,613	22,545,640	0.005882	2,842,917	16,722	57.00
58.00	05800 MRI	62,731	4,624,150	0.013566	419,622	5,693	58.00
59.00	05900 CARDIAC CATHETERIZATION	81,437	5,984,015	0.013609	918,417	12,499	59.00
60.00	06000 LABORATORY	137,847	33,398,115	0.004127	6,913,758	28,533	60.00
65.00	06500 RESPIRATORY THERAPY	25,953	6,884,619	0.003770	2,798,107	10,549	65.00
66.00	06600 PHYSICAL THERAPY	61,875	3,790,474	0.016324	294,020	4,800	66.00
67.00	06700 OCCUPATIONAL THERAPY	4,021	245,929	0.016350	94,646	1,547	67.00
68.00	06800 SPEECH PATHOLOGY	2,637	248,871	0.010596	120,328	1,275	68.00
69.00	06900 ELECTROCARDIOLOGY	100,564	8,096,465	0.012421	1,719,716	21,361	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	13,197	203,000	0.065010	48,058	3,124	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	40,583	4,718,025	0.008602	787,084	6,770	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	96,191	8,387,107	0.011469	1,554,056	17,823	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	86,839	21,730,166	0.003996	5,163,287	20,632	73.00
74.00	07400 RENAL DIALYSIS	517	607,150	0.000852	277,368	236	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	0	76.00
76.01	03060 WOUND CARE	70,979	1,371,692	0.051746	17,904	926	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	43,629	1,755,657	0.024851	1,738	43	90.00
91.00	09100 EMERGENCY	404,598	36,766,846	0.011004	2,825,067	31,087	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	231,029	4,436,029	0.052080	392,400	20,436	92.00
200.00	Total (lines 50-199)	2,458,808	206,221,537		31,709,322	286,454	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140292

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

Worksheet D
Part III
Date/Time Prepared:
5/19/2016 11:40 am

			Title XVIII			Hospital		PPS
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	25,956	0.00	6,504	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,309	0.00	1,048	0		31.00
40.00	04000	SUBPROVIDER - IPF	4,280	0.00	3,022	0		40.00
43.00	04300	NURSERY	697	0.00	0	0		43.00
200.00		Total (lines 30-199)	33,242		10,574	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140292

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

Worksheet D
Part IV
Date/Time Prepared:
5/19/2016 11:40 am

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	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700 CT SCAN	0	0	0	0	0 57.00
58.00	05800 MRI	0	0	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000 LABORATORY	0	0	0	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0 74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0 76.00
76.01	03060 WOUND CARE	0	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0	0	0 90.00
91.00	09100 EMERGENCY	0	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
200.00	Total (lines 50-199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140292

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

Worksheet D Part IV Date/Time Prepared: 5/19/2016 11:40 am

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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	15,002,773	0.000000	0.000000	1,631,452	50.00
51.00	05100	RECOVERY ROOM	0	2,467,905	0.000000	0.000000	241,157	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,287,642	0.000000	0.000000	5,638	52.00
53.00	05300	ANESTHESIOLOGY	0	3,694,410	0.000000	0.000000	434,109	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,700,207	0.000000	0.000000	1,793,922	54.00
56.00	05600	RADIOISOTOPE	0	3,274,650	0.000000	0.000000	414,551	56.00
57.00	05700	CT SCAN	0	22,545,640	0.000000	0.000000	2,842,917	57.00
58.00	05800	MRI	0	4,624,150	0.000000	0.000000	419,622	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,984,015	0.000000	0.000000	918,417	59.00
60.00	06000	LABORATORY	0	33,398,115	0.000000	0.000000	6,913,758	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,884,619	0.000000	0.000000	2,798,107	65.00
66.00	06600	PHYSICAL THERAPY	0	3,790,474	0.000000	0.000000	294,020	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	245,929	0.000000	0.000000	94,646	67.00
68.00	06800	SPEECH PATHOLOGY	0	248,871	0.000000	0.000000	120,328	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,096,465	0.000000	0.000000	1,719,716	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	203,000	0.000000	0.000000	48,058	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,718,025	0.000000	0.000000	787,084	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,387,107	0.000000	0.000000	1,554,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,730,166	0.000000	0.000000	5,163,287	73.00
74.00	07400	RENAL DIALYSIS	0	607,150	0.000000	0.000000	277,368	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0.000000	0	76.00
76.01	03060	WOUND CARE	0	1,371,692	0.000000	0.000000	17,904	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,755,657	0.000000	0.000000	1,738	90.00
91.00	09100	EMERGENCY	0	36,766,846	0.000000	0.000000	2,825,067	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,436,029	0.000000	0.000000	392,400	92.00
200.00		Total (lines 50-199)	0	206,221,537			31,709,322	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140292

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

Worksheet D
Part IV
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		Title XVIII			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	2,511,794	0		50.00
51.00	05100 RECOVERY ROOM	0	510,972	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	529,627	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,361,526	0		54.00
56.00	05600 RADIOISOTOPE	0	605,833	0		56.00
57.00	05700 CT SCAN	0	2,609,364	0		57.00
58.00	05800 MRI	0	649,528	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	1,072,161	0		59.00
60.00	06000 LABORATORY	0	1,553,546	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	106,046	0		65.00
66.00	06600 PHYSICAL THERAPY	0	1,298	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	688	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	805,344	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	8,944	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	818,482	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,533,396	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,296,207	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0		76.00
76.01	03060 WOUND CARE	0	573,712	0		76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	167,334	0		90.00
91.00	09100 EMERGENCY	0	3,114,839	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	686,700	0		92.00
200.00	Total (lines 50-199)	0	21,517,341	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140292

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

Worksheet D
Part V
Date/Time Prepared:
5/19/2016 11:40 am

		Title XVIII		Hospital		PPS		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.276723	2,511,794	0	0	695,071	50.00
51.00	05100	RECOVERY ROOM	0.206478	510,972	0	0	105,504	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.323903	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.053004	529,627	0	0	28,072	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148447	1,361,526	0	0	202,114	54.00
56.00	05600	RADIOISOTOPE	0.134315	605,833	0	0	81,372	56.00
57.00	05700	CT SCAN	0.053880	2,609,364	0	0	140,593	57.00
58.00	05800	MRI	0.100859	649,528	0	0	65,511	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.242868	1,072,161	0	0	260,394	59.00
60.00	06000	LABORATORY	0.122439	1,553,546	0	0	190,215	60.00
65.00	06500	RESPIRATORY THERAPY	0.190524	106,046	0	0	20,204	65.00
66.00	06600	PHYSICAL THERAPY	0.359755	1,298	0	0	467	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.242757	688	0	0	167	67.00
68.00	06800	SPEECH PATHOLOGY	0.113838	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114574	805,344	0	0	92,271	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.266182	8,944	0	0	2,381	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.314669	818,482	0	0	257,551	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.394690	1,533,396	0	0	605,216	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215217	2,296,207	0	43,174	494,183	73.00
74.00	07400	RENAL DIALYSIS	0.383801	0	0	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	0	0	76.00
76.01	03060	WOUND CARE	0.665708	573,712	0	0	381,925	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.282136	167,334	0	0	47,211	90.00
91.00	09100	EMERGENCY	0.147115	3,114,839	0	0	458,240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.726839	686,700	0	0	499,120	92.00
200.00		Subtotal (see instructions)		21,517,341	0	43,174	4,627,782	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		21,517,341	0	43,174	4,627,782	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140292

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

Worksheet D
Part V
Date/Time Prepared:
5/19/2016 11:40 am

		Title XVIII		Hospital	PPS
Cost Center Description		Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600 RADIOISOTOPE	0	0		56.00
57.00	05700 CT SCAN	0	0		57.00
58.00	05800 MRI	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000 LABORATORY	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,292		73.00
74.00	07400 RENAL DIALYSIS	0	0		74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0		76.00
76.01	03060 WOUND CARE	0	0		76.01
OUTPATIENT SERVICE COST CENTERS					
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
200.00	Subtotal (see instructions)	0	9,292		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	9,292		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140292
Component CCN: 14S292

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

Worksheet D
Part II
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	440,936	15,002,773	0.029390	1,550	46	50.00
51.00	05100 RECOVERY ROOM	30,799	2,467,905	0.012480	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	138,810	1,287,642	0.107802	0	0	52.00
53.00	05300 ANESTHESIOLOGY	10,509	3,694,410	0.002845	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	186,442	14,700,207	0.012683	74,940	950	54.00
56.00	05600 RADIOISOTOPE	54,072	3,274,650	0.016512	0	0	56.00
57.00	05700 CT SCAN	132,613	22,545,640	0.005882	79,930	470	57.00
58.00	05800 MRI	62,731	4,624,150	0.013566	19,200	260	58.00
59.00	05900 CARDIAC CATHETERIZATION	81,437	5,984,015	0.013609	0	0	59.00
60.00	06000 LABORATORY	137,847	33,398,115	0.004127	707,866	2,921	60.00
65.00	06500 RESPIRATORY THERAPY	25,953	6,884,619	0.003770	203,225	766	65.00
66.00	06600 PHYSICAL THERAPY	61,875	3,790,474	0.016324	25,311	413	66.00
67.00	06700 OCCUPATIONAL THERAPY	4,021	245,929	0.016350	9,332	153	67.00
68.00	06800 SPEECH PATHOLOGY	2,637	248,871	0.010596	13,765	146	68.00
69.00	06900 ELECTROCARDIOLOGY	100,564	8,096,465	0.012421	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	13,197	203,000	0.065010	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	40,583	4,718,025	0.008602	117	1	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	96,191	8,387,107	0.011469	916	11	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	86,839	21,730,166	0.003996	755,167	3,018	73.00
74.00	07400 RENAL DIALYSIS	517	607,150	0.000852	38,750	33	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	0	76.00
76.01	03060 WOUND CARE	70,979	1,371,692	0.051746	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	43,629	1,755,657	0.024851	0	0	90.00
91.00	09100 EMERGENCY	404,598	36,766,846	0.011004	75,440	830	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4,436,029	0.000000	16,380	0	92.00
200.00	Total (lines 50-199)	2,227,779	206,221,537		2,021,889	10,018	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140292
Component CCN: 14S292

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

Worksheet D
Part IV
Date/Time Prepared:
5/19/2016 11:40 am

		Title XVIII			Subprovider - IPF		PPS	
Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292 Component CCN: 145292	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/19/2016 11:40 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	15,002,773	0.000000	0.000000	1,550	50.00
51.00	05100 RECOVERY ROOM	0	2,467,905	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,287,642	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	3,694,410	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	14,700,207	0.000000	0.000000	74,940	54.00
56.00	05600 RADIOISOTOPE	0	3,274,650	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	22,545,640	0.000000	0.000000	79,930	57.00
58.00	05800 MRI	0	4,624,150	0.000000	0.000000	19,200	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	5,984,015	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	33,398,115	0.000000	0.000000	707,866	60.00
65.00	06500 RESPIRATORY THERAPY	0	6,884,619	0.000000	0.000000	203,225	65.00
66.00	06600 PHYSICAL THERAPY	0	3,790,474	0.000000	0.000000	25,311	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	245,929	0.000000	0.000000	9,332	67.00
68.00	06800 SPEECH PATHOLOGY	0	248,871	0.000000	0.000000	13,765	68.00
69.00	06900 ELECTROCARDIOLOGY	0	8,096,465	0.000000	0.000000	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	203,000	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,718,025	0.000000	0.000000	117	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	8,387,107	0.000000	0.000000	916	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	21,730,166	0.000000	0.000000	755,167	73.00
74.00	07400 RENAL DIALYSIS	0	607,150	0.000000	0.000000	38,750	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0.000000	0	76.00
76.01	03060 WOUND CARE	0	1,371,692	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	1,755,657	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	36,766,846	0.000000	0.000000	75,440	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4,436,029	0.000000	0.000000	16,380	92.00
200.00	Total (lines 50-199)	0	206,221,537			2,021,889	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140292
Component CCN: 14s292

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

Worksheet D
Part IV
Date/Time Prepared:
5/19/2016 11:40 am
PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,725	0		54.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	6,900	0		57.00
58.00	05800 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
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	6,449	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 PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	331	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0		76.00
76.01	03060 WOUND CARE	0	0	0		76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	420	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
200.00	Total (lines 50-199)	0	17,825	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140292 Component CCN: 145292	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/19/2016 11:40 am
	Title XVIII	Subprovider - IPF	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	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.276723	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.206478	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.323903	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.053004	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.148447	3,725	0	0	553	54.00
56.00 05600 RADIOISOTOPE	0.134315	0	0	0	0	56.00
57.00 05700 CT SCAN	0.053880	6,900	0	0	372	57.00
58.00 05800 MRI	0.100859	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.242868	0	0	0	0	59.00
60.00 06000 LABORATORY	0.122439	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.190524	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.359755	6,449	0	0	2,320	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.242757	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.113838	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.114574	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.266182	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.314669	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.394690	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.215217	331	0	759	71	73.00
74.00 07400 RENAL DIALYSIS	0.383801	0	0	0	0	74.00
76.00 03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	0	0	76.00
76.01 03060 WOUND CARE	0.665708	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.282136	420	0	0	118	90.00
91.00 09100 EMERGENCY	0.147115	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.726839	0	0	0	0	92.00
200.00 Subtotal (see instructions)		17,825	0	759	3,434	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		17,825	0	759	3,434	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:140292

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

Worksheet D
Part V
Date/Time Prepared:
5/19/2016 11:40 am

Component CCN:145292

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	163		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03050 BACTERIOLOGY & MICROBIOLOGY	0	0		76.00
76.01 03060 WOUND CARE	0	0		76.01
OUTPATIENT SERVICE COST CENTERS				
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
200.00 Subtotal (see instructions)	0	163		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	163		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140292
Component CCN: 14S292

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

Worksheet D
Part II
Date/Time Prepared:
5/19/2016 11:40 am

Title XIX

Subprovider -
IPF

Tefra

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	440,936	15,002,773	0.029390	0	0	50.00
51.00	05100 RECOVERY ROOM	30,799	2,467,905	0.012480	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	138,810	1,287,642	0.107802	0	0	52.00
53.00	05300 ANESTHESIOLOGY	10,509	3,694,410	0.002845	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	186,442	14,700,207	0.012683	0	0	54.00
56.00	05600 RADIOISOTOPE	54,072	3,274,650	0.016512	0	0	56.00
57.00	05700 CT SCAN	132,613	22,545,640	0.005882	0	0	57.00
58.00	05800 MRI	62,731	4,624,150	0.013566	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	81,437	5,984,015	0.013609	0	0	59.00
60.00	06000 LABORATORY	137,847	33,398,115	0.004127	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	25,953	6,884,619	0.003770	0	0	65.00
66.00	06600 PHYSICAL THERAPY	61,875	3,790,474	0.016324	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	4,021	245,929	0.016350	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	2,637	248,871	0.010596	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	100,564	8,096,465	0.012421	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	13,197	203,000	0.065010	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	40,583	4,718,025	0.008602	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	96,191	8,387,107	0.011469	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	86,839	21,730,166	0.003996	0	0	73.00
74.00	07400 RENAL DIALYSIS	517	607,150	0.000852	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	0	76.00
76.01	03060 WOUND CARE	70,979	1,371,692	0.051746	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	43,629	1,755,657	0.024851	0	0	90.00
91.00	09100 EMERGENCY	404,598	36,766,846	0.011004	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4,436,029	0.000000	0	0	92.00
200.00	Total (lines 50-199)	2,227,779	206,221,537		0	0	200.00

APPORIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140292
Component CCN: 145292

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

Worksheet D
Part IV
Date/Time Prepared:
5/19/2016 11:40 am

Title XIX

Subprovider -
TPF

Tefra

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060 WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140292
Component CCN: 145292

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

Worksheet D
Part IV
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	15,002,773	0.000000	0.000000	0	50.00
51.00	05100 RECOVERY ROOM	0	2,467,905	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,287,642	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	3,694,410	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	14,700,207	0.000000	0.000000	0	54.00
56.00	05600 RADIOISOTOPE	0	3,274,650	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	22,545,640	0.000000	0.000000	0	57.00
58.00	05800 MRI	0	4,624,150	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	5,984,015	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	33,398,115	0.000000	0.000000	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	6,884,619	0.000000	0.000000	0	65.00
66.00	06600 PHYSICAL THERAPY	0	3,790,474	0.000000	0.000000	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	245,929	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	248,871	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	8,096,465	0.000000	0.000000	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	203,000	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,718,025	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	8,387,107	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	21,730,166	0.000000	0.000000	0	73.00
74.00	07400 RENAL DIALYSIS	0	607,150	0.000000	0.000000	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0.000000	0	76.00
76.01	03060 WOUND CARE	0	1,371,692	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	1,755,657	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	36,766,846	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4,436,029	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	206,221,537			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140292
Component CCN: 145292

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

Worksheet D
Part IV
Date/Time Prepared:
5/19/2016 11:40 am

		Title XIX			Subprovider - IPF	Tefra
Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 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
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 PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	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
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0		76.00
76.01	03060 WOUND CARE	0	0	0		76.01
OUTPATIENT SERVICE COST CENTERS						
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
200.00	Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140292

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

Worksheet D-1

Date/Time Prepared:
5/19/2016 11:40 am

Title XVIII		Hospital	PPS
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		25,956 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		25,956 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)		21,880 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)		6,504 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0 14.00
15.00	Total nursery days (title V or XIX only)		0 15.00
16.00	Nursery days (title V or XIX only)		0 16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)		20,532,143 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)		20,532,143 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0 28.00
29.00	Private room charges (excluding swing-bed charges)		0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		20,532,143 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		791.04 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,144,924 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		5,144,924 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140292

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

Worksheet D-1

Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description	Title XVIII			Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	4,140,650	2,309	1,793.27	1,048	1,879,347	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)					5,796,113	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					12,820,384	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)					450,422	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					286,454	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					736,876	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					12,083,508	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					4,076	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					791.04	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					3,224,279	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140292

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

Worksheet D-1
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description	Title XVIII			Hospital	PPS	
	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,471,190	20,532,143	0.071653	3,224,279	231,029	90.00
91.00 Nursing School cost	0	20,532,143	0.000000	3,224,279	0	91.00
92.00 Allied health cost	0	20,532,143	0.000000	3,224,279	0	92.00
93.00 All other Medical Education	0	20,532,143	0.000000	3,224,279	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Component CCN: 14S292		Date/Time Prepared: 5/19/2016 11:40 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,280	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,280	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)		4,280	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)		3,022	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,928,572	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)		3,928,572	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,928,572	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		917.89	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,773,864	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,773,864	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140292
Component CCN: 14S292

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

worksheet D-1
Date/Time Prepared:
5/19/2016 11:40 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					356,924	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,130,788	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)					190,446	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					10,018	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					200,464	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,930,324	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140292 Period: From 01/01/2015 To 12/31/2015 worksheet D-1
 Component CCN: 14S292 Date/Time Prepared: 5/19/2016 11:40 am

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	269,745	3,928,572	0.068662	0	0	90.00
91.00	Nursing School cost	0	3,928,572	0.000000	0	0	91.00
92.00	Allied health cost	0	3,928,572	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,928,572	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140292	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
Component CCN: 14S292		Date/Time Prepared: 5/19/2016 11:40 am
Title XIX	Subprovider - IPF	Tefra

Cost Center Description		1.00	
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,280	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,280	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)	4,280	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)	0	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)	697	15.00
16.00	Nursery days (title V or XIX only)	434	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,928,572	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)	3,928,572	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,928,572	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	917.89	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140292
Component CCN: 145292

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

worksheet D-1
Date/Time Prepared:
5/19/2016 11:40 am

Title XIX

Subprovider -
IPF

Tefra

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			
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	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)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					512	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140292	Period: From 01/01/2015	Worksheet D-1
Component CCN: 145292	To 12/31/2015	Date/Time Prepared: 5/19/2016 11:40 am
Title XIX		Subprovider - IPF
Tefra		

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	3,928,572	0.000000	0	0	90.00
91.00 Nursing School cost	0	3,928,572	0.000000	0	0	91.00
92.00 Allied health cost	0	3,928,572	0.000000	0	0	92.00
93.00 All other Medical Education	0	3,928,572	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140292

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

worksheet D-3

Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT		8,462,549		31.00
40.00	04000 SUBPROVIDER - IPF		2,401,371		40.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.276723	1,631,452	451,460	50.00
51.00	05100 RECOVERY ROOM	0.206478	241,157	49,794	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.323903	5,638	7,464	52.00
53.00	05300 ANESTHESIOLOGY	0.053004	434,109	23,010	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.148447	1,793,922	266,302	54.00
56.00	05600 RADIOISOTOPE	0.134315	414,551	55,680	56.00
57.00	05700 CT SCAN	0.053880	2,842,917	153,176	57.00
58.00	05800 MRI	0.100859	419,622	42,323	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.242868	918,417	223,054	59.00
60.00	06000 LABORATORY	0.122439	6,913,758	846,514	60.00
65.00	06500 RESPIRATORY THERAPY	0.190524	2,798,107	533,107	65.00
66.00	06600 PHYSICAL THERAPY	0.359755	294,020	105,775	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.242757	94,646	22,976	67.00
68.00	06800 SPEECH PATHOLOGY	0.113838	120,328	13,698	68.00
69.00	06900 ELECTROCARDIOLOGY	0.114574	1,719,716	197,035	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.266182	48,058	12,792	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.314669	787,084	247,671	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.394690	1,554,056	613,370	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.215217	5,163,287	1,111,227	73.00
74.00	07400 RENAL DIALYSIS	0.383801	277,368	106,454	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	76.00
76.01	03060 WOUND CARE	0.665708	17,904	11,919	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.282136	1,738	490	90.00
91.00	09100 EMERGENCY	0.147115	2,825,067	415,610	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.726839	392,400	285,212	92.00
200.00	Total (sum of lines 50-94 and 96-98)		31,709,322	5,796,113	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)		31,709,322		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140292
Component CCN: 14S292

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

Worksheet D-3
Date/Time Prepared:
5/19/2016 11:40 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		4,593,440		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.276723	1,550	429	50.00
51.00	05100 RECOVERY ROOM	0.206478	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.323903	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.053004	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.148447	74,940	11,125	54.00
56.00	05600 RADIOISOTOPE	0.134315	0	0	56.00
57.00	05700 CT SCAN	0.053880	79,930	4,307	57.00
58.00	05800 MRI	0.100859	19,200	1,936	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.242868	0	0	59.00
60.00	06000 LABORATORY	0.122439	707,866	86,670	60.00
65.00	06500 RESPIRATORY THERAPY	0.190524	203,225	38,719	65.00
66.00	06600 PHYSICAL THERAPY	0.359755	25,311	9,106	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.242757	9,332	2,265	67.00
68.00	06800 SPEECH PATHOLOGY	0.113838	13,765	1,567	68.00
69.00	06900 ELECTROCARDIOLOGY	0.114574	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.266182	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.314669	117	37	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.394690	916	362	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.215217	755,167	162,525	73.00
74.00	07400 RENAL DIALYSIS	0.383801	38,750	14,872	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	76.00
76.01	03060 WOUND CARE	0.665708	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.282136	0	0	90.00
91.00	09100 EMERGENCY	0.147115	75,440	11,098	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.726839	16,380	11,906	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,021,889	356,924	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)		2,021,889		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140292

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

Worksheet E
Part A
Date/Time Prepared:
5/19/2016 11:40 am

		Title XVIII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		7,699,164	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,767,579	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)		45,631	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)		115.72	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		8.90	30.00
31.00	Percentage of Medicaid patient days (see instructions)		42.43	31.00
32.00	Sum of lines 30 and 31		51.33	32.00
33.00	Allowable disproportionate share percentage (see instructions)		31.56	33.00
34.00	Disproportionate share adjustment (see instructions)		825,826	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140292

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

Worksheet E
Part A
Date/Time Prepared:
5/19/2016 11:40 am

		Title XVIII		Hospital		PPS	
				Prior to October 1	On/After October 1		
		0		1.00	2.00		
Uncompensated Care Adjustment							
35.00	Total uncompensated care amount (see instructions)			7,647,644,885	6,406,145,534		35.00
35.01	Factor 3 (see instructions)			0.000292178	0.000291491		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			2,234,473	1,867,336		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			1,671,263	469,385		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)			2,140,648			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)							
40.00	Total Medicare discharges on worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)				0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)				0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)				0		46.00
47.00	Subtotal (see instructions)				13,478,848		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)				13,478,848		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)				932,814		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)				0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).				0		52.00
53.00	Nursing and Allied Health Managed Care payment				0		53.00
54.00	Special add-on payments for new technologies				0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)				0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).				0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)				0		58.00
59.00	Total (sum of amounts on lines 49 through 58)				14,411,662		59.00
60.00	Primary payer payments				5,821		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)				14,405,841		61.00
62.00	Deductibles billed to program beneficiaries				1,035,280		62.00
63.00	Coinurance billed to program beneficiaries				119,700		63.00
64.00	Allowable bad debts (see instructions)				580,908		64.00
65.00	Adjusted reimbursable bad debts (see instructions)				377,590		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				471,690		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)				13,628,451		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)				0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)				0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0		70.00
70.50	RURAL DEMONSTRATION PROJECT				0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)				0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)				0		70.91
70.92	Bundled Model 1 discount amount (see instructions)				0		70.92
70.93	HVBP payment adjustment amount (see instructions)				-3,948		70.93
70.94	HRR adjustment amount (see instructions)				-4,464		70.94
70.95	Recovery of accelerated depreciation				0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140292

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

Worksheet E
Part A
Date/Time Prepared:
5/19/2016 11:40 am

		Title XVIII	Hospital		PPS
			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		13,620,039		71.00
71.01	Sequestration adjustment (see instructions)		272,401		71.01
72.00	Interim payments		12,910,324		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)		437,314		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		475,743		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

		Title XVIII				Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period on/After 10/01	Total (Col 2 through 4)		
		0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,699,164	0	7,699,164	0	7,699,164	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,767,579	0	0	2,767,579	2,767,579	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	45,631	0	29,108	16,523	45,631	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.01	0	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	0	4.00
Indirect Medical Education Adjustment									
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA									
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	0	9.01
Disproportionate Share Adjustment									
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3156	0.3156	0.3156	0.3156	0.3156	0.3156	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	825,826	0	607,464	218,362	825,826	0	11.00
11.01	uncompensated care payments	36.00	2,140,648	0	1,671,263	469,385	2,140,648	0	11.01
Additional payment for high percentage of ESRD beneficiary discharges									
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	13,478,848	0	10,006,999	3,471,849	13,478,848	0	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,478,848	0	10,006,999	3,471,849	13,478,848	0	15.00
16.00	Payment for inpatient program capital	50.00	932,814	0	685,241	247,573	932,814	0	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	0	18.00

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
19.00	SUBTOTAL		0	10,692,240	3,719,422	14,411,662	19.00	
	w/S L, line	(Amounts from L)						
	0	1.00	2.00	3.00	4.00	5.00		
20.00	Capital DRG other than outlier	1.00	837,618	0	615,619	221,999	837,618	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	3,477	0	3,477	1,265	4,742	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1095	0.1095	0.1095	0.1095		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	91,719	0	67,410	24,309	91,719	25.00
26.00	Total prospective capital payments (see instructions)	12.00	932,814	0	685,241	247,573	932,814	26.00
	w/S E, Part A line	(Amounts to E, Part A)						
	0	1.00	2.00	3.00	4.00	5.00		
27.00	Low volume adjustment factor			0.000000	0.000000			27.00
28.00	Low volume adjustment (transfer amount to wkst. E, Pt. A, line)	70.96		0			0	28.00
29.00	Low volume adjustment (transfer amount to wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to wkst. E, Pt. A.		Y					100.00

		Title XVIII			Hospital	PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,699,164	7,699,164		7,699,164	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,767,579		2,767,579	2,767,579	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	45,631	29,108	16,523	45,631	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3156	0.3156	0.3156		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	825,826	607,464	218,362	825,826	11.00
11.01	Uncompensated care payments	36.00	2,140,648	1,671,263	469,385	2,140,648	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	13,478,848	10,006,999	3,471,849	13,478,848	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,478,848	10,006,999	3,471,849	13,478,848	15.00
16.00	Payment for inpatient program capital	50.00	932,814	686,506	246,308	932,814	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			10,693,505	3,718,157	14,411,662	19.00

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	837,618	615,619	221,999	837,618	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	3,477	3,477	0	3,477	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0	22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1095	0.1095	0.1095	0	24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	91,719	67,410	24,309	91,719	25.00
26.00	Total prospective capital payments (see instructions)	12.00	932,814	686,506	246,308	932,814	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00		70.96	0	0		0	27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-3,948	-7,625	3,677	-3,948	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-4,464	-3,080	-1,384	-4,464	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140292	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/19/2016 11:40 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		9,292	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,627,782	2.00
3.00	PPS payments		3,702,433	3.00
4.00	Outlier payment (see instructions)		21,319	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		9,292	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		43,174	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)		43,174	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		43,174	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		33,882	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)		9,292	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)		3,723,752	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)		713,353	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)		3,019,691	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)		3,019,691	30.00
31.00	Primary payer payments		24	31.00
32.00	Subtotal (line 30 minus line 31)		3,019,667	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		196,922	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		127,999	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		174,658	36.00
37.00	Subtotal (see instructions)		3,147,666	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)		3,147,666	40.00
40.01	Sequestration adjustment (see instructions)		62,953	40.01
41.00	Interim payments		3,119,413	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-34,700	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140292	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/19/2016 11:40 am
		Component CCN: 145292	Title XVIII	Subprovider - IPF
				PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		163	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,434	2.00
3.00	PPS payments		2,137	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0,000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		163	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		759	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)		759	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		759	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		596	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)		163	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)		2,137	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		543	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)		1,757	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)		1,757	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,757	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,757	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)		1,757	40.00
40.01	Sequestration adjustment (see instructions)		35	40.01
41.00	Interim payments		2,306	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-584	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140292

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

Worksheet E-1
Part I
Date/Time Prepared:
5/19/2016 11:40 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		12,850,469		3,107,776		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		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	11/05/2015	59,855	11/05/2015	11,637		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)		59,855		11,637		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)		12,910,324		3,119,413		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		437,314		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		34,700		6.02
7.00	Total Medicare program liability (see instructions)		13,347,638		3,084,713		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: 140292	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part I
Component CCN: 14S292		Date/Time Prepared: 5/19/2016 11:40 am
Title XVIII	Subprovider - IPF	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		2,475,040		2,306	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		2,475,040		2,306	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		27,147		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		584	6.02
7.00	Total Medicare program liability (see instructions)		2,502,187		1,722	7.00
			0	Contractor Number	NPR Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 140292

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

Worksheet E-1
Part II
Date/Time Prepared:
5/19/2016 11:40 am

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from wkst. S-3, Pt. I col. 15 line 14			4,827 1.00
2.00	Medicare days from wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			7,552 2.00
3.00	Medicare HMO days from wkst. S-3, Pt. I, col. 6. line 2			1,041 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			24,189 4.00
5.00	Total hospital charges from wkst C, Pt. I, col. 8 line 200			249,685,843 5.00
6.00	Total hospital charity care charges from wkst. S-10, col. 3 line 20			5,335,682 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: 140292	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part II Date/Time Prepared: 5/19/2016 11:40 am
		Component CCN: 14S292		
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,742,658 1.00
2.00	Net IPF PPS Outlier Payments			5,032 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			11.726027 9.00
10.00	Teaching Adjustment Factor {(1 + (line 8/line 9)) raised to the power of .5150 -1}.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2,747,690 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,747,690 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,747,690 18.00
19.00	Deductibles			143,552 19.00
20.00	Subtotal (line 18 minus line 19)			2,604,138 20.00
21.00	Coinsurance			78,581 21.00
22.00	Subtotal (line 20 minus line 21)			2,525,557 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			42,608 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			27,695 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			32,868 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,553,252 26.00
27.00	Direct graduate medical education payments (from wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			2,553,252 31.00
31.01	Sequestration adjustment (see instructions)			51,065 31.01
32.00	Interim payments			2,475,040 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			27,147 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from worksheet E-3, Part II, line 2			5,032 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 140292

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

Worksheet G

Date/Time Prepared:
5/19/2016 11:40 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	949,140	0	0	0	1.00
2.00	Temporary investments	1,205	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	18,416,503	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,866,355	0	0	0	6.00
7.00	Inventory	1,897,700	0	0	0	7.00
8.00	Prepaid expenses	692,656	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	18,090,849	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,869,112	0	0	0	12.00
13.00	Land improvements	438,336	0	0	0	13.00
14.00	Accumulated depreciation	-90,125	0	0	0	14.00
15.00	Buildings	26,830,006	0	0	0	15.00
16.00	Accumulated depreciation	-13,912,799	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	7,943,886	0	0	0	19.00
20.00	Accumulated depreciation	-6,888,853	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	14,630,592	0	0	0	23.00
24.00	Accumulated depreciation	-10,895,646	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)	19,924,509	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	844,875	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	8,848,113	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,692,988	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	47,708,346	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,455,335	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,182,876	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	690,593	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	5,041,126	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,369,930	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,479,634	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	19,244	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,498,878	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,868,808	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	24,839,538	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)	24,839,538	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	47,708,346	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140292

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

worksheet G-1

Date/Time Prepared:
5/19/2016 11:40 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		23,464,786		0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		4,078,885			2.00
3.00	Total (sum of line 1 and line 2)		27,543,671		0	3.00
4.00	DONOR RESTRICTED FUND BALANCE	117,789		0		4.00
5.00	ROUNDING	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)		117,789		0	10.00
11.00	Subtotal (line 3 plus line 10)		27,661,460		0	11.00
12.00	GENERAL FUND BALANCE	2,821,783		0		12.00
13.00	ROUNDING	139		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)		2,821,922		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		24,839,538		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	DONOR RESTRICTED FUND BALANCE		0			4.00
5.00	ROUNDING		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	GENERAL FUND BALANCE		0			12.00
13.00	ROUNDING		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: 140292

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/19/2016 11:40 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	31,338,723		31,338,723	1.00
2.00	SUBPROVIDER - IPF	6,505,600		6,505,600	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	37,844,323		37,844,323	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,247,058		5,247,058	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,247,058		5,247,058	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	43,091,381		43,091,381	17.00
18.00	Ancillary services	78,361,116	91,544,984	169,906,100	18.00
19.00	Outpatient services	7,948,759	28,820,612	36,769,371	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHARMACY	0	742,962	742,962	27.00
27.01	PHYSICIAN REVENUE	0	609,464	609,464	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	129,401,256	121,718,022	251,119,278	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		87,666,401		29.00
30.00	BAD DEBT	4,034,229			30.00
31.00	ROUNDING	133			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)		4,034,362		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)		91,700,763		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140292

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

Worksheet G-3

Date/Time Prepared:
5/19/2016 11:40 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	251,119,278	1.00
2.00	Less contractual allowances and discounts on patients' accounts	164,159,961	2.00
3.00	Net patient revenues (line 1 minus line 2)	86,959,317	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	91,700,763	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,741,446	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	EHR REVENUE	8,820,331	24.00
25.00	Total other income (sum of lines 6-24)	8,820,331	25.00
26.00	Total (line 5 plus line 25)	4,078,885	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,078,885	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140292	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/19/2016 11:40 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		837,618	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		3,477	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)		66.44	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)		8.90	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		42.43	8.00
9.00	Sum of lines 7 and 8		51.33	9.00
10.00	Allowable disproportionate share percentage (see instructions)		10.95	10.00
11.00	Disproportionate share adjustment (see instructions)		91,719	11.00
12.00	Total prospective capital payments (see instructions)		932,814	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00