This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140103	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/31/2016 4:22 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/31/2016 Time: 4:22 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. BERNARD HOSPITAL (140103) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

CFO
Title

05/31/2016
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-383,572	-25,541	-151,339	0	1.00
2.00	Subprovider - IPF	0	-14,749	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-398,321	-25,541	-151,339	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2016 4:21 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 64TH & DAN RYAN	PO Box:			1.00
2.00	City: CHICAGO	State: IL	Zip Code: 60621	County: COOK	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	ST. BERNARD HOSPITAL	140103	16974	1	07/01/1967	N	P	P	3.00
4.00	Subprovider - IPF	ST. BERNARD HOSPITAL PSYCH UNIT	14S103	16974	4	01/01/1994	N	P	P	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: 1.00	To: 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.	11,807	4,789	75	0	345	235	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2016 4:21 pm

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2016 4:21 pm

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

	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: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2016 4:21 pm

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	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	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N	109.00

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

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			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)		N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	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)		0 168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.50 169.00

		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: 140103	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/31/2016 4:21 pm

			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2016 4:21 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	04/04/2016	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2016 4:21 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					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?		N			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
		1.00	2.00			
	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.	TONY	LEONE			41.00
42.00	Enter the employer/company name of the cost report preparer.	TONY LEONE, CPA				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023	TONY@LEONE-CONSULTING.COM			43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2016 4:21 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	04/04/2016			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		CONSULTANT		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2016 4:21 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	148	54,020	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)		148	54,020	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)		158	57,670	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	40	14,600		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)		198				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2016 4:21 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,153	4,436	20,839			1.00
2.00	HMO and other (see instructions)	1,276	10,976				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,153	4,436	20,839			7.00
8.00	INTENSIVE CARE UNIT	834	555	2,986			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1,284	2,396			13.00
14.00	Total (see instructions)	5,987	6,275	26,221	3.36	708.93	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,219	3,005	11,588	0.00	45.22	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				3.36	754.15	27.00
28.00	Observation Bed Days		0	1,084			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2016 4:21 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,157	1,867	5,825	1.00
2.00	HMO and other (see instructions)			268	1,773		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	1,157	1,867	5,825	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	275	441	1,604	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: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2016 4:21 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	42,898,704	0	42,898,704	1,558,110.00	27.53	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		210,559	0	210,559	2,080.00	101.23	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)		367,008	0	367,008	8,944.00	41.03	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		2,808,829	705,956	3,514,785	136,514.00	25.75	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,313,134	0	2,313,134	63,800.00	36.26	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		25,650	0	25,650	202.00	126.98	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	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)		9,951,808	0	9,951,808			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		892,915	0	892,915			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		53,491	0	53,491			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	288,716	0	288,716	7,962.00	36.26	26.00
27.00	Administrative & General	5.00	6,062,471	-129,334	5,933,137	174,197.00	34.06	27.00
28.00	Administrative & General under contract (see inst.)		361,032	0	361,032	1,062.00	339.95	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,305,335	0	2,305,335	107,774.00	21.39	30.00
31.00	Laundry & Linen Service	8.00	73,904	0	73,904	6,233.00	11.86	31.00
32.00	Housekeeping	9.00	1,399,533	0	1,399,533	108,271.00	12.93	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	912,750	-488,496	424,254	35,221.00	12.05	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	455,303	455,303	35,055.00	12.99	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,505,133	0	1,505,133	36,436.00	41.31	38.00
39.00	Central Services and Supply	14.00	335,143	0	335,143	21,225.00	15.79	39.00
40.00	Pharmacy	15.00	1,407,681	0	1,407,681	42,877.00	32.83	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2016 4:21 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	562,731	0	562,731	29,107.00	19.33	41.00
42.00	Social Service	17.00	1,319,258	-295,494	1,023,764	29,692.00	34.48	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part III Date/Time Prepared: 5/31/2016 4:21 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		42,682,169	0	42,682,169	1,548,148.00	27.57	1.00
2.00	Excluded area salaries (see instructions)		2,808,829	705,956	3,514,785	136,514.00	25.75	2.00
3.00	Subtotal salaries (line 1 minus line 2)		39,873,340	-705,956	39,167,384	1,411,634.00	27.75	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,338,784	0	2,338,784	64,002.00	36.54	4.00
5.00	Subtotal wage-related costs (see inst.)		9,951,808	0	9,951,808	0.00	25.41	5.00
6.00	Total (sum of lines 3 thru 5)		52,163,932	-705,956	51,457,976	1,475,636.00	34.87	6.00
7.00	Total overhead cost (see instructions)		16,533,687	-458,021	16,075,666	635,112.00	25.31	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 5/31/2016 4:21 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	765,756	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	6,062,582	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)	69,960	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)	123,705	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	627,685	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	3,098,034	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	140,888	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	9,604	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,898,214	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COST	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part V Date/Time Prepared: 5/31/2016 4:21 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	2,313,134	10,898,214	1.00
2.00	Hospital	2,313,134	9,951,808	2.00
3.00	Subprovider - IPF	0	750,956	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	195,450	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-7 | Date/Time Prepared: 5/31/2016 4:21 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	0	0	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	0	0	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-7 | Date/Time Prepared: 5/31/2016 4:21 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	0			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140103	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 5/31/2016 4:21 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.481308	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	25,523,956	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,500,000	5.00
6.00	Medicaid charges	113,178,776	6.00
7.00	Medicaid cost (line 1 times line 6)	54,473,850	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)	26,449,894	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	26,449,894	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	7,676,866	0	7,676,866	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	3,694,937	0	3,694,937	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	3,694,937	0	3,694,937	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,951,402	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	259,177	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,692,225	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	814,481	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,509,418	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	30,959,312	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/31/2016 4:21 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,305,368	4,305,368	-2,137,319	2,168,049	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	3,202,955	3,202,955	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	288,716	7,716,204	8,004,920	-3,616	8,001,304	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,062,471	16,353,840	22,416,311	-212,652	22,203,659	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,305,335	2,967,803	5,273,138	-253,157	5,019,981	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,904	370,221	444,125	0	444,125	8.00
9.00	00900	HOUSEKEEPING	1,399,533	494,947	1,894,480	0	1,894,480	9.00
10.00	01000	DIETARY	912,750	1,952,855	2,865,605	-1,467,615	1,397,990	10.00
11.00	01100	CAFETERIA	0	29	29	1,429,436	1,429,465	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,505,133	388,894	1,894,027	-1,376	1,892,651	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	335,143	395,779	730,922	-368,170	362,752	14.00
15.00	01500	PHARMACY	1,407,681	1,696,531	3,104,212	-1,531,128	1,573,084	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	562,731	482,060	1,044,791	-1,849	1,042,942	16.00
17.00	01700	SOCIAL SERVICE	1,319,258	422,734	1,741,992	-299,387	1,442,605	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	367,008	367,008	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,338,393	4,117,508	14,455,901	-3,296,429	11,159,472	30.00
31.00	03100	INTENSIVE CARE UNIT	2,156,259	419,451	2,575,710	-247,946	2,327,764	31.00
40.00	04000	SUBPROVIDER - IPF	2,379,370	494,560	2,873,930	570,768	3,444,698	40.00
43.00	04300	NURSERY	0	364,075	364,075	1,442,809	1,806,884	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,282,006	597,832	1,879,838	-443,473	1,436,365	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	136	148,199	148,335	1,112,174	1,260,509	52.00
53.00	05300	ANESTHESIOLOGY	24,696	1,715,631	1,740,327	-109,358	1,630,969	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,239,286	1,274,646	3,513,932	-400,502	3,113,430	54.00
60.00	06000	LABORATORY	2,293,620	2,322,971	4,616,591	-202,191	4,414,400	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,747,008	1,747,008	129,957	1,876,965	65.00
66.00	06600	PHYSICAL THERAPY	434,763	77,710	512,473	-3,793	508,680	66.00
69.00	06900	ELECTROCARDIOLOGY	0	142,306	142,306	-142,306	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,089,998	2,089,998	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	182,491	182,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,779,647	1,779,647	73.00
74.00	07400	RENAL DIALYSIS	0	358,778	358,778	-14,194	344,584	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	991,954	1,480,401	2,472,355	-103,911	2,368,444	90.00
91.00	09100	EMERGENCY	4,156,107	4,998,564	9,154,671	-1,186,419	7,968,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		49,192	49,192	-49,192	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,469,245	57,856,097	100,325,342	-168,740	100,156,602	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	188,929	209,718	398,647	0	398,647	192.00
194.00	07950	OUTPATIENT PHARMACY	240,530	737,491	978,021	-3,590	974,431	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	172,330	172,330	194.01
200.00		TOTAL (SUM OF LINES 118-199)	42,898,704	58,803,306	101,702,010	0	101,702,010	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/31/2016 4:21 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	2,168,049		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-51,292	3,151,663		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-589,391	7,411,913		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-458,914	21,744,745		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	-89,517	4,930,464		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	444,125		8.00
9.00	00900	HOUSEKEEPING	0	1,894,480		9.00
10.00	01000	DIETARY	-566,812	831,178		10.00
11.00	01100	CAFETERIA	0	1,429,465		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	1,892,651		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	362,752		14.00
15.00	01500	PHARMACY	0	1,573,084		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-30,284	1,012,658		16.00
17.00	01700	SOCIAL SERVICE	0	1,442,605		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	367,008		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,036,822	9,122,650		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,327,764		31.00
40.00	04000	SUBPROVIDER - IPF	-273,798	3,170,900		40.00
43.00	04300	NURSERY	-264,915	1,541,969		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,436,365		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,260,509		52.00
53.00	05300	ANESTHESIOLOGY	-1,602,494	28,475		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,113,430		54.00
60.00	06000	LABORATORY	-212,427	4,201,973		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	1,876,965		65.00
66.00	06600	PHYSICAL THERAPY	0	508,680		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,089,998		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	182,491		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,779,647		73.00
74.00	07400	RENAL DIALYSIS	0	344,584		74.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-1,234,066	1,134,378		90.00
91.00	09100	EMERGENCY	-3,636,276	4,331,976		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-11,047,008	89,109,594		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	398,647		192.00
194.00	07950	OUTPATIENT PHARMACY	0	974,431		194.00
194.01	07951	PUBLIC RELATIONS	0	172,330		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-11,047,008	90,655,002		200.00

RECLASSIFICATIONS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/31/2016 4:21 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASSIFY POST PARTUM				
1.00	NURSERY	43.00	1,374,393	162,777	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,086,654	128,700	2.00
	TOTALS		2,461,047	291,477	
	B - RECLASSIFY INTERNS & RESIDENTS				
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	367,008	1.00
	TOTALS		0	367,008	
	C - RECLASSIFY MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,272,489	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	TOTALS		0	2,272,489	
	D - RECLASSIFY DRUGS SOLD				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,779,647	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	TOTALS		0	1,779,647	
	E - RECLASSIFY DIETARY COSTS				
1.00	SUBPROVIDER - IPF	40.00	33,193	2,142	1.00
	TOTALS		33,193	2,142	
	F - RECLASSIFY SOCIAL SERVICE				
1.00	EMERGENCY	91.00	35,839	0	1.00
2.00	SUBPROVIDER - IPF	40.00	259,655	0	2.00
	TOTALS		295,494	0	
	G - RECLASSIFY EMERGENCY ROOM				
1.00	SUBPROVIDER - IPF	40.00	283,774	21,283	1.00
	TOTALS		283,774	21,283	
	H - RECLASSIFY DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,374,309	1.00
	TOTALS		0	2,374,309	
	I - RECLASSIFY PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	236,990	1.00
	TOTALS		0	236,990	
	J - RECLASSIFY INTEREST EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	49,192	1.00
	TOTALS		0	49,192	
	K - RECLASSIFY EQUIPMENT RENTAL				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	779,454	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00

RECLASSIFICATIONS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/31/2016 4:21 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	TOTALS		0	779,454	
	L - RECLASSIFY CAFETERIA COSTS				
1.00	CAFETERIA	11.00	455,303	974,133	1.00
	TOTALS		455,303	974,133	
	M - RECLASS EKG COSTS				
1.00	RESPIRATORY THERAPY	65.00	0	142,306	1.00
	TOTALS		0	142,306	
	P - RECLASS PR COSTS				
1.00	PUBLIC RELATIONS	194.01	129,334	42,996	1.00
	TOTALS		129,334	42,996	
	Q - RECLASS IMPLANT COSTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	182,491	1.00
	TOTALS		0	182,491	
500.00	Grand Total: Increases		3,658,145	9,515,917	500.00

RECLASSIFICATIONS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/31/2016 4:21 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASSIFY POST PARTUM						
1.00	ADULTS & PEDIATRICS	30.00	1,374,393	162,777	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	1,086,654	128,700	0		2.00
	TOTALS		2,461,047	291,477			
	B - RECLASSIFY INTERNS & RESIDENTS						
1.00	EMERGENCY	91.00	0	367,008	0		1.00
	TOTALS		0	367,008			
	C - RECLASSIFY MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	151,512	0		1.00
2.00	PHARMACY	15.00	0	24,484	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	474,658	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	228,737	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	18,944	0		5.00
6.00	NURSERY	43.00	0	65,991	0		6.00
7.00	OPERATING ROOM	50.00	0	420,401	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	85,665	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	82,059	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	70,245	0		10.00
11.00	LABORATORY	60.00	0	55,977	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	10,956	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	3,793	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	335	0		14.00
15.00	RENAL DIALYSIS	74.00	0	13,935	0		15.00
16.00	CLINIC	90.00	0	74	0		16.00
17.00	CLINIC	90.00	0	102,922	0		17.00
18.00	EMERGENCY	91.00	0	461,801	0		18.00
	TOTALS		0	2,272,489			
	D - RECLASSIFY DRUGS SOLD						
1.00	CENTRAL SERVICES & SUPPLY	14.00		7,060	0		1.00
2.00	PHARMACY	15.00		1,505,734	0		2.00
3.00	ADULTS & PEDIATRICS	30.00		62,509	0		3.00
4.00	INTENSIVE CARE UNIT	31.00		19,209	0		4.00
5.00	SUBPROVIDER - IPF	40.00		8,979	0		5.00
6.00	NURSERY	43.00		28,370	0		6.00
7.00	OPERATING ROOM	50.00		19,205	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00		16,549	0		8.00
9.00	ANESTHESIOLOGY	53.00		27,299	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00		554	0		10.00
11.00	RENAL DIALYSIS	74.00		259	0		11.00
12.00	CLINIC	90.00		915	0		12.00
13.00	EMERGENCY	91.00		83,005	0		13.00
	TOTALS		0	1,779,647			
	E - RECLASSIFY DIETARY COSTS						
1.00	DIETARY	10.00	33,193	2,142	0		1.00
	TOTALS		33,193	2,142			
	F - RECLASSIFY SOCIAL SERVICE						
1.00	SOCIAL SERVICE	17.00	35,839	0	0		1.00
2.00	SOCIAL SERVICE	17.00	259,655	0	0		2.00
	TOTALS		295,494	0			
	G - RECLASSIFY EMERGENCY ROOM						
1.00	EMERGENCY	91.00	283,774	21,283	0		1.00
	TOTALS		283,774	21,283			
	H - RECLASSIFY DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,374,309	9		1.00
	TOTALS		0	2,374,309			
	I - RECLASSIFY PROPERTY INSURANCE						
1.00	OPERATION OF PLANT	7.00	0	236,990	12		1.00
	TOTALS		0	236,990			
	J - RECLASSIFY INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	49,192	11		1.00
	TOTALS		0	49,192			
	K - RECLASSIFY EQUIPMENT RENTAL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,616	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	40,322	0		2.00
3.00	OPERATION OF PLANT	7.00	0	16,167	0		3.00
4.00	DIETARY	10.00	0	2,844	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	1,376	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	209,598	0		6.00
7.00	PHARMACY	15.00	0	910	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,849	0		8.00
9.00	SOCIAL SERVICE	17.00	0	3,893	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	6,738	0		10.00
11.00	SUBPROVIDER - IPF	40.00	0	1,356	0		11.00
12.00	OPERATING ROOM	50.00	0	3,867	0		12.00

RECLASSIFICATIONS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/31/2016 4:21 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	966	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	329,703	0		14.00
15.00	LABORATORY	60.00	0	146,214	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	1,058	0		16.00
17.00	EMERGENCY	91.00	0	5,387	0		17.00
18.00	OUTPATIENT PHARMACY	194.00	0	3,590	0		18.00
	TOTALS		0	779,454			
	L - RECLASSIFY CAFETERIA COSTS						
1.00	DIETARY	10.00	455,303	974,133	0		1.00
	TOTALS		455,303	974,133			
	M - RECLASS EKG COSTS						
1.00	ELECTROCARDIOLOGY	69.00	0	142,306	0		1.00
	TOTALS		0	142,306			
	P - RECLASS PR COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	129,334	42,996	0		1.00
	TOTALS		129,334	42,996			
	Q - RECLASS IMPLANT COSTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	182,491	0		1.00
	TOTALS		0	182,491			
500.00	Grand Total: Decreases		3,658,145	9,515,917			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2016 4:21 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,192,754	0	0	0	0	1.00
2.00	Land Improvements	3,357,222	37,660	0	37,660	0	2.00
3.00	Buildings and Fixtures	50,035,309	1,930,147	0	1,930,147	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	44,341,350	1,762,555	0	1,762,555	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	99,926,635	3,730,362	0	3,730,362	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	99,926,635	3,730,362	0	3,730,362	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,192,754	0	1.00
2.00	Land Improvements	3,394,882	0	2.00
3.00	Buildings and Fixtures	51,965,456	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	46,103,905	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	103,656,997	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	103,656,997	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/31/2016 4:21 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,305,368	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)	4,305,368	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	4,305,368	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	4,305,368	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2016 4:21 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	55,637,667	0	55,637,667	0.536748	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	48,019,329	0	48,019,329	0.463252	0	2.00
3.00	Total (sum of lines 1-2)	103,656,996	0	103,656,996	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,931,059	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,372,209	779,454	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,303,268	779,454	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	236,990	0	0	2,168,049	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,151,663	2.00
3.00	Total (sum of lines 1-2)	0	236,990	0	0	5,319,712	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/31/2016 4:21 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-49,192	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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-8,283,329			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-566,812	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-30,284	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	B	-2,100	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	SISTERS MAINTENANCE	B	-12,000	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	DISCOUNTS	B	-1,615	ADMINISTRATIVE & GENERAL	5.00	0	34.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/31/2016 4:21 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
35.00			0		0.00	0	35.00
38.00	MISCELLANEOUS REVENUE	B	-133,576	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	EMPLOYEE ROOM RENTALS	B	-36,810	OPERATION OF PLANT	7.00	0	39.00
40.00	ANESTHESIOLOGIST BILLING EXPENS	A	-27,602	ANESTHESIOLOGY	53.00	0	40.00
41.00	ER PHYSICIAN BILLING EXPENSE	A	-228,980	EMERGENCY	91.00	0	41.00
42.00	OFFSET DENTAL CLINIC COSTS	A	-476,046	CLINIC	90.00	0	42.00
42.01	PEDS VAN	A	-249,653	ADULTS & PEDIATRICS	30.00	0	42.01
43.00	OFFSET OTHER LOBBYING COSTS	A	-180,000	ADMINISTRATIVE & GENERAL	5.00	0	43.00
45.00			0		0.00	0	45.00
45.01	OTHER MISC INCOME	B	-19,547	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	GAIN FROM PENSION LIQUIDATION	B	-589,391	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.02
45.03	MCHC REFUND	B	-34,659	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	WATER RECLAMATION REFUND	B	-52,707	OPERATION OF PLANT	7.00	0	45.04
45.05	OTHER MISC INCOME	B	-61,719	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	LOBBY DUES	A	-10,986	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,047,008				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2016 4:21 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	26,274	0	26,274	221,000	202	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,787,169	1,787,169	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	273,798	273,798	0	0	0	3.00
4.00	43.00	NURSERY	264,915	264,915	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	1,574,892	1,574,892	0	0	0	5.00
6.00	60.00	LABORATORY	212,427	212,427	0	0	0	6.00
7.00	90.00	CLINIC	758,020	758,020	0	0	0	7.00
8.00	91.00	EMERGENCY	3,407,296	3,407,296	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			8,304,791	8,278,517	26,274		202	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	5.00	ADMINISTRATIVE & GENERAL	21,462	1,073	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	43.00	NURSERY	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	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			21,462	1,073	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	5.00	ADMINISTRATIVE & GENERAL	0	21,462	4,812	4,812		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,787,169		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	273,798		3.00
4.00	43.00	NURSERY	0	0	0	264,915		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	1,574,892		5.00
6.00	60.00	LABORATORY	0	0	0	212,427		6.00
7.00	90.00	CLINIC	0	0	0	758,020		7.00
8.00	91.00	EMERGENCY	0	0	0	3,407,296		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	21,462	4,812	8,283,329		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/31/2016 4:21 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,168,049	2,168,049				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,151,663		3,151,663			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,411,913	5,253	7,636	7,424,802		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,744,745	713,881	1,037,757	1,033,849	24,530,232	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,930,464	303,243	440,821	401,705	6,076,233	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	444,125	11,870	17,256	12,878	486,129	8.00
9.00	00900	HOUSEKEEPING	1,894,480	27,773	40,374	243,869	2,206,496	9.00
10.00	01000	DIETARY	831,178	36,349	52,840	73,926	994,293	10.00
11.00	01100	CAFETERIA	1,429,465	15,476	22,497	79,337	1,546,775	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,892,651	26,370	38,334	262,269	2,219,624	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	362,752	17,733	25,779	58,399	464,663	14.00
15.00	01500	PHARMACY	1,573,084	14,810	21,529	245,288	1,854,711	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,012,658	54,992	79,941	98,056	1,245,647	16.00
17.00	01700	SOCIAL SERVICE	1,442,605	8,570	12,458	178,391	1,642,024	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	367,008	0	0	0	367,008	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,122,650	235,854	342,858	1,372,639	11,074,001	30.00
31.00	03100	INTENSIVE CARE UNIT	2,327,764	44,508	64,701	375,728	2,812,701	31.00
40.00	04000	SUBPROVIDER - IPF	3,170,900	91,723	133,337	515,082	3,911,042	40.00
43.00	04300	NURSERY	1,541,969	12,026	17,482	239,488	1,810,965	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,436,365	87,524	127,233	223,390	1,874,512	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,260,509	35,833	52,090	189,373	1,537,805	52.00
53.00	05300	ANESTHESIOLOGY	28,475	3,095	4,499	4,303	40,372	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,113,430	45,313	65,870	390,196	3,614,809	54.00
60.00	06000	LABORATORY	4,201,973	53,256	77,417	399,663	4,732,309	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,876,965	36,959	53,727	0	1,967,651	65.00
66.00	06600	PHYSICAL THERAPY	508,680	16,097	23,400	75,757	623,934	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,089,998	0	0	0	2,089,998	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	182,491	0	0	0	182,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,779,647	0	0	0	1,779,647	73.00
74.00	07400	RENAL DIALYSIS	344,584	0	0	0	344,584	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,134,378	21,234	30,867	172,848	1,359,327	90.00
91.00	09100	EMERGENCY	4,331,976	76,686	111,477	680,999	5,201,138	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)	89,109,594	1,996,428	2,902,180	7,327,433	88,591,121	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	398,647	166,008	241,323	32,921	838,899	192.00
194.00	07950	OUTPATIENT PHARMACY	974,431	5,613	8,160	41,912	1,030,116	194.00
194.01	07951	PUBLIC RELATIONS	172,330	0	0	22,536	194,866	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	90,655,002	2,168,049	3,151,663	7,424,802	90,655,002	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/31/2016 4:21 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	24,530,232					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	2,254,094	0	8,330,327			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	180,339	0	86,311	752,779		8.00
9.00	00900	HOUSEKEEPING	818,542	0	201,943	0	3,226,981	9.00
10.00	01000	DIETARY	368,852	0	264,297	0	106,052	10.00
11.00	01100	CAFETERIA	573,806	0	112,527	0	45,153	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	823,412	0	191,739	0	76,938	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	172,376	0	128,942	0	51,740	14.00
15.00	01500	PHARMACY	688,040	0	107,687	0	43,211	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	462,096	0	399,853	0	160,446	16.00
17.00	01700	SOCIAL SERVICE	609,140	0	62,313	0	25,004	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	136,149	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,108,101	0	1,714,925	414,906	688,133	30.00
31.00	03100	INTENSIVE CARE UNIT	1,043,425	0	323,625	59,451	129,859	31.00
40.00	04000	SUBPROVIDER - IPF	1,450,875	0	666,933	230,718	267,615	40.00
43.00	04300	NURSERY	671,812	0	87,440	47,704	35,086	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	695,386	0	636,401	0	255,364	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	570,478	0	260,546	0	104,547	52.00
53.00	05300	ANESTHESIOLOGY	14,977	0	22,505	0	9,031	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,340,982	0	329,473	0	132,205	54.00
60.00	06000	LABORATORY	1,755,540	0	387,229	0	155,380	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	729,938	0	268,733	0	107,833	65.00
66.00	06600	PHYSICAL THERAPY	231,460	0	117,044	0	46,965	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	775,324	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,699	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	660,194	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	127,830	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	504,268	0	154,392	0	61,952	90.00
91.00	09100	EMERGENCY	1,929,461	0	557,592	0	223,741	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)	23,764,596	0	7,082,450	752,779	2,726,255	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	311,206	0	1,207,061	0	484,348	192.00
194.00	07950	OUTPATIENT PHARMACY	382,141	0	40,816	0	16,378	194.00
194.01	07951	PUBLIC RELATIONS	72,289	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24,530,232	0	8,330,327	752,779	3,226,981	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/31/2016 4:21 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,733,494					10.00
11.00	01100	CAFETERIA	0	2,278,261				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	75,756	0	3,387,469		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	44,105	0	0	861,826	14.00
15.00	01500	PHARMACY	0	89,117	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	60,492	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	83,237	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	980,394	467,812	0	1,314,722	0	30.00
31.00	03100	INTENSIVE CARE UNIT	117,067	118,736	0	257,665	0	31.00
40.00	04000	SUBPROVIDER - IPF	636,033	195,530	0	543,052	0	40.00
43.00	04300	NURSERY	0	172,138	0	201,009	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	89,333	0	193,818	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	136,076	0	158,924	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,675	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	165,522	0	0	0	54.00
60.00	06000	LABORATORY	0	162,365	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	22,355	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	797,762	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	64,064	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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	81,507	0	176,892	0	90.00
91.00	09100	EMERGENCY	0	281,059	0	541,387	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)	1,733,494	2,248,815	0	3,387,469	861,826	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,934	0	0	0	192.00
194.00	07950	OUTPATIENT PHARMACY	0	17,512	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,733,494	2,278,261	0	3,387,469	861,826	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/31/2016 4:21 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	
			15.00	16.00	17.00	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,782,766					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,328,534				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,421,718			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		503,157	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	434,070	1,334,767	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	83,151	191,257	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	166,851	742,227	0	0	40.00
43.00	04300	NURSERY	0	54,017	153,467	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	63,925	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,880	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	8,672	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	252,490	0	0	0	54.00
60.00	06000	LABORATORY	0	550,965	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	131,996	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,609	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	90,673	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,754	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,782,766	203,743	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	26,956	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	9,183	0	0	0	90.00
91.00	09100	EMERGENCY	0	221,599	0	0	503,157	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)	2,782,766	2,328,534	2,421,718	0	503,157	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OUTPATIENT PHARMACY	0	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,782,766	2,328,534	2,421,718	0	503,157	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/31/2016 4:21 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	22,531,831	0	22,531,831		30.00
31.00	03100	INTENSIVE CARE UNIT	5,136,937	0	5,136,937		31.00
40.00	04000	SUBPROVIDER - IPF	8,810,876	0	8,810,876		40.00
43.00	04300	NURSERY	3,233,638	0	3,233,638		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,808,739	0	3,808,739		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,782,256	0	2,782,256		52.00
53.00	05300	ANESTHESIOLOGY	99,232	0	99,232		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,835,481	0	5,835,481		54.00
60.00	06000	LABORATORY	7,743,788	0	7,743,788		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	3,206,151	0	3,206,151		65.00
66.00	06600	PHYSICAL THERAPY	1,054,367	0	1,054,367		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,753,757	0	3,753,757		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	318,008	0	318,008		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,426,350	0	5,426,350		73.00
74.00	07400	RENAL DIALYSIS	499,370	0	499,370		74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2,347,521	0	2,347,521		90.00
91.00	09100	EMERGENCY	9,459,134	-503,157	8,955,977		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)	86,047,436	-503,157	85,544,279		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,853,448	0	2,853,448		192.00
194.00	07950	OUTPATIENT PHARMACY	1,486,963	0	1,486,963		194.00
194.01	07951	PUBLIC RELATIONS	267,155	0	267,155		194.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	90,655,002	-503,157	90,151,845		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/31/2016 4:21 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,253	7,636	12,889	12,889	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	713,881	1,037,757	1,751,638	1,792	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	303,243	440,821	744,064	696	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,870	17,256	29,126	22	8.00
9.00	00900	HOUSEKEEPING	0	27,773	40,374	68,147	423	9.00
10.00	01000	DIETARY	0	36,349	52,840	89,189	128	10.00
11.00	01100	CAFETERIA	0	15,476	22,497	37,973	138	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	26,370	38,334	64,704	455	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,733	25,779	43,512	101	14.00
15.00	01500	PHARMACY	0	14,810	21,529	36,339	425	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	54,992	79,941	134,933	170	16.00
17.00	01700	SOCIAL SERVICE	0	8,570	12,458	21,028	309	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	235,854	342,858	578,712	2,400	30.00
31.00	03100	INTENSIVE CARE UNIT	0	44,508	64,701	109,209	651	31.00
40.00	04000	SUBPROVIDER - IPF	0	91,723	133,337	225,060	893	40.00
43.00	04300	NURSERY	0	12,026	17,482	29,508	415	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	87,524	127,233	214,757	387	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	35,833	52,090	87,923	328	52.00
53.00	05300	ANESTHESIOLOGY	0	3,095	4,499	7,594	7	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	45,313	65,870	111,183	676	54.00
60.00	06000	LABORATORY	0	53,256	77,417	130,673	693	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	36,959	53,727	90,686	0	65.00
66.00	06600	PHYSICAL THERAPY	0	16,097	23,400	39,497	131	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	21,234	30,867	52,101	300	90.00
91.00	09100	EMERGENCY	0	76,686	111,477	188,163	1,180	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)	0	1,996,428	2,902,180	4,898,608	12,720	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	166,008	241,323	407,331	57	192.00
194.00	07950	OUTPATIENT PHARMACY	0	5,613	8,160	13,773	73	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	39	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	2,168,049	3,151,663	5,319,712	12,889	202.00

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		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	1,753,430					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	161,123	0	905,883			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,891	0	9,386	51,425		8.00
9.00	00900	HOUSEKEEPING	58,510	0	21,960	0	149,040	9.00
10.00	01000	DIETARY	26,366	0	28,741	0	4,898	10.00
11.00	01100	CAFETERIA	41,016	0	12,237	0	2,085	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	58,858	0	20,851	0	3,553	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,321	0	14,022	0	2,390	14.00
15.00	01500	PHARMACY	49,181	0	11,710	0	1,996	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,031	0	43,482	0	7,410	16.00
17.00	01700	SOCIAL SERVICE	43,542	0	6,776	0	1,155	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	9,732	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	293,649	0	186,490	28,344	31,783	30.00
31.00	03100	INTENSIVE CARE UNIT	74,584	0	35,193	4,061	5,998	31.00
40.00	04000	SUBPROVIDER - IPF	103,709	0	72,526	15,761	12,360	40.00
43.00	04300	NURSERY	48,021	0	9,509	3,259	1,620	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,706	0	69,206	0	11,794	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	40,778	0	28,333	0	4,829	52.00
53.00	05300	ANESTHESIOLOGY	1,071	0	2,447	0	417	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	95,854	0	35,829	0	6,106	54.00
60.00	06000	LABORATORY	125,487	0	42,109	0	7,176	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	52,176	0	29,223	0	4,980	65.00
66.00	06600	PHYSICAL THERAPY	16,545	0	12,728	0	2,169	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	55,420	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,839	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,191	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	9,137	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	36,045	0	16,789	0	2,861	90.00
91.00	09100	EMERGENCY	137,919	0	60,635	0	10,334	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)	1,698,702	0	770,182	51,425	125,914	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,245	0	131,262	0	22,370	192.00
194.00	07950	OUTPATIENT PHARMACY	27,316	0	4,439	0	756	194.00
194.01	07951	PUBLIC RELATIONS	5,167	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,753,430	0	905,883	51,425	149,040	202.00

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		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	149,322					10.00
11.00	01100	CAFETERIA	0	93,449				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	3,107	0	151,528		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,809	0	0	74,155	14.00
15.00	01500	PHARMACY	0	3,655	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,481	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,414	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,451	19,190	0	58,809	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,084	4,870	0	11,526	0	31.00
40.00	04000	SUBPROVIDER - IPF	54,787	8,020	0	24,292	0	40.00
43.00	04300	NURSERY	0	7,061	0	8,992	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,664	0	8,670	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,582	0	7,109	0	52.00
53.00	05300	ANESTHESIOLOGY	0	151	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,789	0	0	0	54.00
60.00	06000	LABORATORY	0	6,660	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	917	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	68,643	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,512	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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,343	0	7,913	0	90.00
91.00	09100	EMERGENCY	0	11,528	0	24,217	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)	149,322	92,241	0	151,528	74,155	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	490	0	0	0	192.00
194.00	07950	OUTPATIENT PHARMACY	0	718	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	149,322	93,449	0	151,528	74,155	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/31/2016 4:21 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	
			15.00	16.00	17.00	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	103,306					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	221,507				16.00
17.00	01700	SOCIAL SERVICE	0	0	76,224			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		9,732	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	41,283	42,012			30.00
31.00	03100	INTENSIVE CARE UNIT	0	7,908	6,020			31.00
40.00	04000	SUBPROVIDER - IPF	0	15,869	23,362			40.00
43.00	04300	NURSERY	0	5,137	4,830			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,080	0			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,320	0			52.00
53.00	05300	ANESTHESIOLOGY	0	825	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,014	0			54.00
60.00	06000	LABORATORY	0	52,447	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	12,554	0			65.00
66.00	06600	PHYSICAL THERAPY	0	1,199	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,624	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	357	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	103,306	19,377	0			73.00
74.00	07400	RENAL DIALYSIS	0	2,564	0			74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	873	0			90.00
91.00	09100	EMERGENCY	0	21,076	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)	103,306	221,507	76,224	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
194.00	07950	OUTPATIENT PHARMACY	0	0	0			194.00
194.01	07951	PUBLIC RELATIONS	0	0	0			194.01
200.00		Cross Foot Adjustments				0	9,732	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	103,306	221,507	76,224	0	9,732	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/31/2016 4:21 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,367,123	0	1,367,123		30.00
31.00	03100	INTENSIVE CARE UNIT	270,104	0	270,104		31.00
40.00	04000	SUBPROVIDER - IPF	556,639	0	556,639		40.00
43.00	04300	NURSERY	118,352	0	118,352		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	364,264	0	364,264		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	176,202	0	176,202		52.00
53.00	05300	ANESTHESIOLOGY	12,512	0	12,512		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	280,451	0	280,451		54.00
60.00	06000	LABORATORY	365,245	0	365,245		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	189,619	0	189,619		65.00
66.00	06600	PHYSICAL THERAPY	73,186	0	73,186		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	132,687	0	132,687		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,708	0	10,708		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	169,874	0	169,874		73.00
74.00	07400	RENAL DIALYSIS	11,701	0	11,701		74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	120,225	0	120,225		90.00
91.00	09100	EMERGENCY	455,052	0	455,052		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)	4,673,944	0	4,673,944		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	583,755	0	583,755		192.00
194.00	07950	OUTPATIENT PHARMACY	47,075	0	47,075		194.00
194.01	07951	PUBLIC RELATIONS	5,206	0	5,206		194.01
200.00		Cross Foot Adjustments	9,732	0	9,732		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	5,319,712	0	5,319,712		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/31/2016 4:21 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	390,858					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		390,858				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	947	947	42,609,988			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	128,699	128,699	5,933,137	-24,530,232	66,124,770	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	54,669	54,669	2,305,335	0	6,076,233	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,140	2,140	73,904	0	486,129	8.00
9.00	00900	HOUSEKEEPING	5,007	5,007	1,399,533	0	2,206,496	9.00
10.00	01000	DIETARY	6,553	6,553	424,254	0	994,293	10.00
11.00	01100	CAFETERIA	2,790	2,790	455,303	0	1,546,775	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,754	4,754	1,505,133	0	2,219,624	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,197	3,197	335,143	0	464,663	14.00
15.00	01500	PHARMACY	2,670	2,670	1,407,681	0	1,854,711	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,914	9,914	562,731	0	1,245,647	16.00
17.00	01700	SOCIAL SERVICE	1,545	1,545	1,023,764	0	1,642,024	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	367,008	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,520	42,520	7,877,346	0	11,074,001	30.00
31.00	03100	INTENSIVE CARE UNIT	8,024	8,024	2,156,259	0	2,812,701	31.00
40.00	04000	SUBPROVIDER - IPF	16,536	16,536	2,955,992	0	3,911,042	40.00
43.00	04300	NURSERY	2,168	2,168	1,374,393	0	1,810,965	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,779	15,779	1,282,006	0	1,874,512	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,460	6,460	1,086,790	0	1,537,805	52.00
53.00	05300	ANESTHESIOLOGY	558	558	24,696	0	40,372	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,169	8,169	2,239,286	0	3,614,809	54.00
60.00	06000	LABORATORY	9,601	9,601	2,293,620	0	4,732,309	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	6,663	6,663	0	0	1,967,651	65.00
66.00	06600	PHYSICAL THERAPY	2,902	2,902	434,763	0	623,934	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,089,998	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	182,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,779,647	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	344,584	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,828	3,828	991,954	0	1,359,327	90.00
91.00	09100	EMERGENCY	13,825	13,825	3,908,172	0	5,201,138	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)	359,918	359,918	42,051,195	-24,530,232	64,060,889	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,928	29,928	188,929	0	838,899	192.00
194.00	07950	OUTPATIENT PHARMACY	1,012	1,012	240,530	0	1,030,116	194.00
194.01	07951	PUBLIC RELATIONS	0	0	129,334	0	194,866	194.01
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)	2,168,049	3,151,663	7,424,802		24,530,232	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.546897	8.063448	0.174250		0.370969	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,889		1,753,430	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000302		0.026517	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/31/2016 4:21 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	206,543				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,140	37,809			8.00
9.00	00900	HOUSEKEEPING	0	5,007	0	199,396		9.00
10.00	01000	DIETARY	0	6,553	0	6,553	110,540	10.00
11.00	01100	CAFETERIA	0	2,790	0	2,790	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	4,754	0	4,754	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,197	0	3,197	0	14.00
15.00	01500	PHARMACY	0	2,670	0	2,670	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,914	0	9,914	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,545	0	1,545	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	42,520	20,839	42,520	62,517	30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,024	2,986	8,024	7,465	31.00
40.00	04000	SUBPROVIDER - IPF	0	16,536	11,588	16,536	40,558	40.00
43.00	04300	NURSERY	0	2,168	2,396	2,168	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,779	0	15,779	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,460	0	6,460	0	52.00
53.00	05300	ANESTHESIOLOGY	0	558	0	558	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,169	0	8,169	0	54.00
60.00	06000	LABORATORY	0	9,601	0	9,601	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	6,663	0	6,663	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,902	0	2,902	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,828	0	3,828	0	90.00
91.00	09100	EMERGENCY	0	13,825	0	13,825	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)	0	175,603	37,809	168,456	110,540	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	29,928	0	29,928	0	192.00
194.00	07950	OUTPATIENT PHARMACY	0	1,012	0	1,012	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
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)	0	8,330,327	752,779	3,226,981	1,733,494	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	40.332168	19.910048	16.183780	15.682052	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	905,883	51,425	149,040	149,322	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	4.385929	1.360126	0.747457	1.350841	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/31/2016 4:21 pm

		Cost Center Description	CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	52,689					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	1,752	0	750,905			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,020	0	0	2,454,980		14.00
15.00	01500	PHARMACY	2,061	0	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,399	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,925	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,819	0	291,436	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,746	0	57,117	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	4,522	0	120,379	0	0	40.00
43.00	04300	NURSERY	3,981	0	44,558	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,066	0	42,964	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,147	0	35,229	0	0	52.00
53.00	05300	ANESTHESIOLOGY	85	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,828	0	0	0	0	54.00
60.00	06000	LABORATORY	3,755	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	517	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,272,489	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	182,491	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,885	0	39,212	0	0	90.00
91.00	09100	EMERGENCY	6,500	0	120,010	0	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)	52,008	0	750,905	2,454,980	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	276	0	0	0	0	192.00
194.00	07950	OUTPATIENT PHARMACY	405	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
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)	2,278,261	0	3,387,469	861,826	2,782,766	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.239784	0.000000	4.511182	0.351052	27,827.660000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	93,449	0	151,528	74,155	103,306	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.773596	0.000000	0.201794	0.030206	1,033.060000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/31/2016 4:21 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			16.00	17.00	21.00	22.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	177,732,910					16.00
17.00	01700	SOCIAL SERVICE	0	37,809				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		100		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,132,580	20,839	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	6,346,933	2,986	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	12,735,778	11,588	0	0		40.00
43.00	04300	NURSERY	4,123,107	2,396	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,879,418	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,059,496	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	661,915	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,272,582	0	0	0		54.00
60.00	06000	LABORATORY	42,050,924	0	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	10,075,234	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	962,453	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,921,106	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	286,511	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,551,721	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	2,057,528	0	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	700,959	0	0	0		90.00
91.00	09100	EMERGENCY	16,914,665	0	0	100		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)	177,732,910	37,809	0	100		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OUTPATIENT PHARMACY	0	0	0	0		194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0		194.01
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)	2,328,534	2,421,718	0	503,157		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.013101	64.051363	0.000000	5,031.570000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	221,507	76,224	0	9,732		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001246	2.016028	0.000000	97.320000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/31/2016 4:21 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,531,831		22,531,831	0	22,531,831	30.00
31.00	03100	INTENSIVE CARE UNIT	5,136,937		5,136,937	0	5,136,937	31.00
40.00	04000	SUBPROVIDER - IPF	8,810,876		8,810,876	0	8,810,876	40.00
43.00	04300	NURSERY	3,233,638		3,233,638	0	3,233,638	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,808,739		3,808,739	0	3,808,739	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,782,256		2,782,256	0	2,782,256	52.00
53.00	05300	ANESTHESIOLOGY	99,232		99,232	0	99,232	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,835,481		5,835,481	0	5,835,481	54.00
60.00	06000	LABORATORY	7,743,788		7,743,788	0	7,743,788	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,206,151	0	3,206,151	0	3,206,151	65.00
66.00	06600	PHYSICAL THERAPY	1,054,367	0	1,054,367	0	1,054,367	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,753,757		3,753,757	0	3,753,757	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	318,008		318,008	0	318,008	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,426,350		5,426,350	0	5,426,350	73.00
74.00	07400	RENAL DIALYSIS	499,370		499,370	0	499,370	74.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,347,521		2,347,521	0	2,347,521	90.00
91.00	09100	EMERGENCY	8,955,977		8,955,977	0	8,955,977	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,114,103		1,114,103		1,114,103	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	86,658,382	0	86,658,382	0	86,658,382	200.00
201.00		Less Observation Beds	1,114,103		1,114,103		1,114,103	201.00
202.00		Total (see instructions)	85,544,279	0	85,544,279	0	85,544,279	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/31/2016 4:21 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,643,056		29,643,056			30.00
31.00	03100	INTENSIVE CARE UNIT	6,346,933		6,346,933			31.00
40.00	04000	SUBPROVIDER - IPF	12,735,778		12,735,778			40.00
43.00	04300	NURSERY	4,123,107		4,123,107			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,776,452	2,102,966	4,879,418	0.780572	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,052,542	6,954	1,059,496	2.626018	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	378,736	283,179	661,915	0.149917	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,953,059	13,319,523	19,272,582	0.302787	0.000000	54.00
60.00	06000	LABORATORY	20,522,053	21,528,871	42,050,924	0.184153	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	8,277,072	1,798,162	10,075,234	0.318221	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	358,258	604,195	962,453	1.095500	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,937,681	1,983,425	6,921,106	0.542364	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	206,777	79,734	286,511	1.109933	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,961,795	2,589,926	15,551,721	0.348923	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,981,256	76,272	2,057,528	0.242704	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	106,315	594,644	700,959	3.349013	0.000000	90.00
91.00	09100	EMERGENCY	2,939,843	13,974,822	16,914,665	0.529480	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	961,770	2,527,754	3,489,524	0.319271	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	116,262,483	61,470,427	177,732,910			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	116,262,483	61,470,427	177,732,910			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/31/2016 4:21 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.780572	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.626018	52.00
53.00	05300	ANESTHESIOLOGY	0.149917	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.302787	54.00
60.00	06000	LABORATORY	0.184153	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.318221	65.00
66.00	06600	PHYSICAL THERAPY	1.095500	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.542364	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.109933	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348923	73.00
74.00	07400	RENAL DIALYSIS	0.242704	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	3.349013	90.00
91.00	09100	EMERGENCY	0.529480	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.319271	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: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/31/2016 4:21 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,531,831		22,531,831	0	22,531,831	30.00
31.00	03100	INTENSIVE CARE UNIT	5,136,937		5,136,937	0	5,136,937	31.00
40.00	04000	SUBPROVIDER - IPF	8,810,876		8,810,876	0	8,810,876	40.00
43.00	04300	NURSERY	3,233,638		3,233,638	0	3,233,638	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,808,739		3,808,739	0	3,808,739	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,782,256		2,782,256	0	2,782,256	52.00
53.00	05300	ANESTHESIOLOGY	99,232		99,232	0	99,232	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,835,481		5,835,481	0	5,835,481	54.00
60.00	06000	LABORATORY	7,743,788		7,743,788	0	7,743,788	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,206,151	0	3,206,151	0	3,206,151	65.00
66.00	06600	PHYSICAL THERAPY	1,054,367	0	1,054,367	0	1,054,367	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,753,757		3,753,757	0	3,753,757	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	318,008		318,008	0	318,008	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,426,350		5,426,350	0	5,426,350	73.00
74.00	07400	RENAL DIALYSIS	499,370		499,370	0	499,370	74.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,347,521		2,347,521	0	2,347,521	90.00
91.00	09100	EMERGENCY	8,955,977		8,955,977	0	8,955,977	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,114,103		1,114,103		1,114,103	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	86,658,382	0	86,658,382	0	86,658,382	200.00
201.00		Less Observation Beds	1,114,103		1,114,103		1,114,103	201.00
202.00		Total (see instructions)	85,544,279	0	85,544,279	0	85,544,279	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,643,056		29,643,056			30.00
31.00	03100	INTENSIVE CARE UNIT	6,346,933		6,346,933			31.00
40.00	04000	SUBPROVIDER - IPF	12,735,778		12,735,778			40.00
43.00	04300	NURSERY	4,123,107		4,123,107			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,776,452	2,102,966	4,879,418	0.780572	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,052,542	6,954	1,059,496	2.626018	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	378,736	283,179	661,915	0.149917	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,953,059	13,319,523	19,272,582	0.302787	0.000000	54.00
60.00	06000	LABORATORY	20,522,053	21,528,871	42,050,924	0.184153	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	8,277,072	1,798,162	10,075,234	0.318221	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	358,258	604,195	962,453	1.095500	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,937,681	1,983,425	6,921,106	0.542364	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	206,777	79,734	286,511	1.109933	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,961,795	2,589,926	15,551,721	0.348923	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,981,256	76,272	2,057,528	0.242704	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	106,315	594,644	700,959	3.349013	0.000000	90.00
91.00	09100	EMERGENCY	2,939,843	13,974,822	16,914,665	0.529480	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	961,770	2,527,754	3,489,524	0.319271	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	116,262,483	61,470,427	177,732,910			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	116,262,483	61,470,427	177,732,910			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.780572	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.626018	52.00
53.00	05300	ANESTHESIOLOGY	0.149917	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.302787	54.00
60.00	06000	LABORATORY	0.184153	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.318221	65.00
66.00	06600	PHYSICAL THERAPY	1.095500	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.542364	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.109933	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348923	73.00
74.00	07400	RENAL DIALYSIS	0.242704	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	3.349013	90.00
91.00	09100	EMERGENCY	0.529480	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.319271	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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II | Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,808,739	364,264	3,444,475	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,782,256	176,202	2,606,054	0	0	52.00
53.00	05300	ANESTHESIOLOGY	99,232	12,512	86,720	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,835,481	280,451	5,555,030	0	0	54.00
60.00	06000	LABORATORY	7,743,788	365,245	7,378,543	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,206,151	189,619	3,016,532	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,054,367	73,186	981,181	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,753,757	132,687	3,621,070	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	318,008	10,708	307,300	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,426,350	169,874	5,256,476	0	0	73.00
74.00	07400	RENAL DIALYSIS	499,370	11,701	487,669	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,347,521	120,225	2,227,296	0	0	90.00
91.00	09100	EMERGENCY	8,955,977	455,052	8,500,925	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,114,103	67,598	1,046,505	0	0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	46,945,100	2,429,324	44,515,776	0	0	200.00
201.00		Less Observation Beds	1,114,103	67,598	1,046,505	0	0	201.00
202.00		Total (line 200 minus line 201)	45,830,997	2,361,726	43,469,271	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II | Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,808,739	4,879,418	0.780572		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,782,256	1,059,496	2.626018		52.00
53.00	05300	ANESTHESIOLOGY	99,232	661,915	0.149917		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,835,481	19,272,582	0.302787		54.00
60.00	06000	LABORATORY	7,743,788	42,050,924	0.184153		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	3,206,151	10,075,234	0.318221		65.00
66.00	06600	PHYSICAL THERAPY	1,054,367	962,453	1.095500		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,753,757	6,921,106	0.542364		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	318,008	286,511	1.109933		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,426,350	15,551,721	0.348923		73.00
74.00	07400	RENAL DIALYSIS	499,370	2,057,528	0.242704		74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2,347,521	700,959	3.349013		90.00
91.00	09100	EMERGENCY	8,955,977	16,914,665	0.529480		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,114,103	3,489,524	0.319271		92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	46,945,100	124,884,036			200.00
201.00		Less Observation Beds	1,114,103	0			201.00
202.00		Total (line 200 minus line 201)	45,830,997	124,884,036			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,367,123	0	1,367,123	21,923	62.36	30.00
31.00	INTENSIVE CARE UNIT	270,104		270,104	2,986	90.46	31.00
40.00	SUBPROVIDER - IPF	556,639	0	556,639	11,588	48.04	40.00
43.00	NURSERY	118,352		118,352	2,396	49.40	43.00
200.00	Total (lines 30-199)	2,312,218		2,312,218	38,893		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	5,153	321,341		30.00
31.00	INTENSIVE CARE UNIT	834	75,444		31.00
40.00	SUBPROVIDER - IPF	2,219	106,601		40.00
43.00	NURSERY	0	0		43.00
200.00	Total (lines 30-199)	8,206	503,386		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	364,264	4,879,418	0.074653	120,209	8,974	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	176,202	1,059,496	0.166307	9,801	1,630	52.00
53.00	05300	ANESTHESIOLOGY	12,512	661,915	0.018903	36,740	694	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	280,451	19,272,582	0.014552	1,570,971	22,861	54.00
60.00	06000	LABORATORY	365,245	42,050,924	0.008686	5,605,062	48,686	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	189,619	10,075,234	0.018820	1,632,144	30,717	65.00
66.00	06600	PHYSICAL THERAPY	73,186	962,453	0.076041	151,529	11,522	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	132,687	6,921,106	0.019171	2,182,754	41,846	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,708	286,511	0.037374	71,471	2,671	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	169,874	15,551,721	0.010923	2,801,445	30,600	73.00
74.00	07400	RENAL DIALYSIS	11,701	2,057,528	0.005687	707,498	4,024	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	120,225	700,959	0.171515	3,807	653	90.00
91.00	09100	EMERGENCY	455,052	16,914,665	0.026903	672,824	18,101	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	67,598	3,489,524	0.019372	23,722	460	92.00
200.00		Total (lines 50-199)	2,429,324	124,884,036		15,589,977	223,439	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,923	0.00	5,153	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,986	0.00	834	0		31.00
40.00	04000	SUBPROVIDER - IPF	11,588	0.00	2,219	0		40.00
43.00	04300	NURSERY	2,396	0.00	0	0		43.00
200.00		Total (lines 30-199)	38,893		8,206	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
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: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,879,418	0.000000	0.000000	120,209	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,059,496	0.000000	0.000000	9,801	52.00
53.00	05300	ANESTHESIOLOGY	0	661,915	0.000000	0.000000	36,740	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,272,582	0.000000	0.000000	1,570,971	54.00
60.00	06000	LABORATORY	0	42,050,924	0.000000	0.000000	5,605,062	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	10,075,234	0.000000	0.000000	1,632,144	65.00
66.00	06600	PHYSICAL THERAPY	0	962,453	0.000000	0.000000	151,529	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,921,106	0.000000	0.000000	2,182,754	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	286,511	0.000000	0.000000	71,471	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,551,721	0.000000	0.000000	2,801,445	73.00
74.00	07400	RENAL DIALYSIS	0	2,057,528	0.000000	0.000000	707,498	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	700,959	0.000000	0.000000	3,807	90.00
91.00	09100	EMERGENCY	0	16,914,665	0.000000	0.000000	672,824	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,489,524	0.000000	0.000000	23,722	92.00
200.00		Total (lines 50-199)	0	124,884,036			15,589,977	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	42,423	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	10,253	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,228,581	0		54.00
60.00	06000	LABORATORY	0	1,433,054	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	271,912	0		65.00
66.00	06600	PHYSICAL THERAPY	0	1,123	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	256,394	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,438	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	202,579	0		73.00
74.00	07400	RENAL DIALYSIS	0	16,344	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	79,105	0		90.00
91.00	09100	EMERGENCY	0	1,111,761	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	204,485	0		92.00
200.00		Total (lines 50-199)	0	4,890,452	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.780572	42,423	0	0	33,114	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.626018	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.149917	10,253	0	0	1,537	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.302787	1,228,581	0	0	371,998	54.00
60.00	06000	LABORATORY	0.184153	1,433,054	0	0	263,901	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.318221	271,912	0	0	86,528	65.00
66.00	06600	PHYSICAL THERAPY	1.095500	1,123	0	0	1,230	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.542364	256,394	0	0	139,059	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.109933	32,438	0	0	36,004	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348923	202,579	0	3,120	70,684	73.00
74.00	07400	RENAL DIALYSIS	0.242704	16,344	0	0	3,967	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3.349013	79,105	0	0	264,924	90.00
91.00	09100	EMERGENCY	0.529480	1,111,761	0	0	588,655	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.319271	204,485	0	0	65,286	92.00
200.00		Subtotal (see instructions)		4,890,452	0	3,120	1,926,887	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		4,890,452	0	3,120	1,926,887	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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	1,089		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		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	1,089		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	1,089		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140103 | Component CCN: 14S103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II | Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	364,264	4,879,418	0.074653	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	176,202	1,059,496	0.166307	0	0	52.00
53.00	05300	ANESTHESIOLOGY	12,512	661,915	0.018903	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	280,451	19,272,582	0.014552	28,397	413	54.00
60.00	06000	LABORATORY	365,245	42,050,924	0.008686	489,823	4,255	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	189,619	10,075,234	0.018820	20,401	384	65.00
66.00	06600	PHYSICAL THERAPY	73,186	962,453	0.076041	4,487	341	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	132,687	6,921,106	0.019171	3,622	69	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,708	286,511	0.037374	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	169,874	15,551,721	0.010923	346,470	3,784	73.00
74.00	07400	RENAL DIALYSIS	11,701	2,057,528	0.005687	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	120,225	700,959	0.171515	163	28	90.00
91.00	09100	EMERGENCY	455,052	16,914,665	0.026903	130,896	3,521	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,489,524	0.000000	0	0	92.00
200.00		Total (lines 50-199)	2,361,726	124,884,036		1,024,259	12,795	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140103 | Component CCN: 14S103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/31/2016 4:21 pm

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
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
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: 140103 | Component CCN: 14S103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,879,418	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,059,496	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	661,915	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,272,582	0.000000	0.000000	28,397	54.00
60.00	06000	LABORATORY	0	42,050,924	0.000000	0.000000	489,823	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	10,075,234	0.000000	0.000000	20,401	65.00
66.00	06600	PHYSICAL THERAPY	0	962,453	0.000000	0.000000	4,487	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,921,106	0.000000	0.000000	3,622	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	286,511	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,551,721	0.000000	0.000000	346,470	73.00
74.00	07400	RENAL DIALYSIS	0	2,057,528	0.000000	0.000000	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	700,959	0.000000	0.000000	163	90.00
91.00	09100	EMERGENCY	0	16,914,665	0.000000	0.000000	130,896	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,489,524	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	124,884,036			1,024,259	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140103 | Component CCN: 14S103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Subprovider - IPF | 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
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	3,633	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	2,028	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
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
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		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	5,661	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140103 | Component CCN: 14S103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.780572	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.626018	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.149917	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.302787	3,633	0	0	1,100	54.00
60.00	06000	LABORATORY	0.184153	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.318221	2,028	0	0	645	65.00
66.00	06600	PHYSICAL THERAPY	1.095500	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.542364	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.109933	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348923	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.242704	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3.349013	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.529480	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.319271	0	0	0	0	92.00
200.00		Subtotal (see instructions)		5,661	0	0	1,745	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		5,661	0	0	1,745	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140103 | Component CCN: 14S103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		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	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,367,123	0	1,367,123	21,923	62.36	30.00
31.00	INTENSIVE CARE UNIT	270,104		270,104	2,986	90.46	31.00
40.00	SUBPROVIDER - IPF	556,639	0	556,639	11,588	48.04	40.00
43.00	NURSERY	118,352		118,352	2,396	49.40	43.00
200.00	Total (lines 30-199)	2,312,218		2,312,218	38,893		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	4,436	276,629		30.00
31.00	INTENSIVE CARE UNIT	555	50,205		31.00
40.00	SUBPROVIDER - IPF	3,005	144,360		40.00
43.00	NURSERY	1,284	63,430		43.00
200.00	Total (lines 30-199)	9,280	534,624		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	364,264	4,879,418	0.074653	1,120,176	83,624	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	176,202	1,059,496	0.166307	221,779	36,883	52.00
53.00	05300	ANESTHESIOLOGY	12,512	661,915	0.018903	107,408	2,030	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	280,451	19,272,582	0.014552	1,784,510	25,968	54.00
60.00	06000	LABORATORY	365,245	42,050,924	0.008686	6,124,518	53,198	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	189,619	10,075,234	0.018820	2,847,393	53,588	65.00
66.00	06600	PHYSICAL THERAPY	73,186	962,453	0.076041	49,930	3,797	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	132,687	6,921,106	0.019171	1,031,724	19,779	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,708	286,511	0.037374	39,103	1,461	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	169,874	15,551,721	0.010923	3,738,794	40,839	73.00
74.00	07400	RENAL DIALYSIS	11,701	2,057,528	0.005687	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	120,225	700,959	0.171515	51,183	8,779	90.00
91.00	09100	EMERGENCY	455,052	16,914,665	0.026903	541,993	14,581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	67,598	3,489,524	0.019372	0	0	92.00
200.00		Total (lines 50-199)	2,429,324	124,884,036		17,658,511	344,527	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,923	0.00	4,436	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,986	0.00	555	0		31.00
40.00	04000	SUBPROVIDER - IPF	11,588	0.00	3,005	0		40.00
43.00	04300	NURSERY	2,396	0.00	1,284	0		43.00
200.00		Total (lines 30-199)	38,893		9,280	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
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: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,879,418	0.000000	0.000000	1,120,176	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,059,496	0.000000	0.000000	221,779	52.00
53.00	05300	ANESTHESIOLOGY	0	661,915	0.000000	0.000000	107,408	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,272,582	0.000000	0.000000	1,784,510	54.00
60.00	06000	LABORATORY	0	42,050,924	0.000000	0.000000	6,124,518	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	10,075,234	0.000000	0.000000	2,847,393	65.00
66.00	06600	PHYSICAL THERAPY	0	962,453	0.000000	0.000000	49,930	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,921,106	0.000000	0.000000	1,031,724	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	286,511	0.000000	0.000000	39,103	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,551,721	0.000000	0.000000	3,738,794	73.00
74.00	07400	RENAL DIALYSIS	0	2,057,528	0.000000	0.000000	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	700,959	0.000000	0.000000	51,183	90.00
91.00	09100	EMERGENCY	0	16,914,665	0.000000	0.000000	541,993	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,489,524	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	124,884,036			17,658,511	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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
60.00	06000	LABORATORY	0	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
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
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140103 | Component CCN: 14S103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II | Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	364,264	4,879,418	0.074653	613	46	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	176,202	1,059,496	0.166307	0	0	52.00
53.00	05300	ANESTHESIOLOGY	12,512	661,915	0.018903	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	280,451	19,272,582	0.014552	110,953	1,615	54.00
60.00	06000	LABORATORY	365,245	42,050,924	0.008686	866,895	7,530	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	189,619	10,075,234	0.018820	77,236	1,454	65.00
66.00	06600	PHYSICAL THERAPY	73,186	962,453	0.076041	10,220	777	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	132,687	6,921,106	0.019171	7,436	143	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,708	286,511	0.037374	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	169,874	15,551,721	0.010923	880,552	9,618	73.00
74.00	07400	RENAL DIALYSIS	11,701	2,057,528	0.005687	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	120,225	700,959	0.171515	0	0	90.00
91.00	09100	EMERGENCY	455,052	16,914,665	0.026903	281,793	7,581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,489,524	0.000000	0	0	92.00
200.00		Total (lines 50-199)	2,361,726	124,884,036		2,235,698	28,764	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140103 | Component CCN: 14S103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | 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
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
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: 140103 | Component CCN: 14S103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,879,418	0.000000	0.000000	613	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,059,496	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	661,915	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,272,582	0.000000	0.000000	110,953	54.00
60.00	06000	LABORATORY	0	42,050,924	0.000000	0.000000	866,895	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	10,075,234	0.000000	0.000000	77,236	65.00
66.00	06600	PHYSICAL THERAPY	0	962,453	0.000000	0.000000	10,220	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,921,106	0.000000	0.000000	7,436	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	286,511	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,551,721	0.000000	0.000000	880,552	73.00
74.00	07400	RENAL DIALYSIS	0	2,057,528	0.000000	0.000000	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	700,959	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	16,914,665	0.000000	0.000000	281,793	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,489,524	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	124,884,036			2,235,698	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140103 | Component CCN: 14S103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Subprovider - IPF | 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
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
60.00	06000	LABORATORY	0	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
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
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		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: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/31/2016 4:21 pm

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)	21,923	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,923	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)	20,839	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,153	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)	22,531,831	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)	22,531,831	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)	22,531,831	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,027.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,296,099	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)	5,296,099	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,136,937	2,986	1,720.34	834	1,434,764	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)	5,107,267	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	11,838,130	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)	396,785	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	223,439	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	620,224	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	11,217,906	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)	1,084	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,027.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,114,103	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,367,123	22,531,831	0.060675	1,114,103	67,598	90.00
91.00	Nursing School cost	0	22,531,831	0.000000	1,114,103	0	91.00
92.00	Allied health cost	0	22,531,831	0.000000	1,114,103	0	92.00
93.00	All other Medical Education	0	22,531,831	0.000000	1,114,103	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140103 Component CCN: 14S103	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/31/2016 4:21 pm
	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)	11,588	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,588	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)	11,588	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)	2,219	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)	8,810,876	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)	8,810,876	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)	8,810,876	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)	760.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,687,194	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)	1,687,194	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140103 | Component CCN: 14S103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	302,916	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,990,110	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)	106,601	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	12,795	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	119,396	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,870,714	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: 140103 Component CCN: 14S103	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/31/2016 4:21 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	556,639	8,810,876	0.063176	0	0	90.00
91.00	Nursing School cost	0	8,810,876	0.000000	0	0	91.00
92.00	Allied health cost	0	8,810,876	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,810,876	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | 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)	21,923	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,923	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)	20,839	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)	4,436	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)	2,396	15.00
16.00	Nursery days (title V or XIX only)	1,284	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)	22,531,831	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)	22,531,831	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)	22,531,831	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,027.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,559,188	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	4,559,188	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	3,233,638	2,396	1,349.60	1,284	1,732,886	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,136,937	2,986	1,720.34	555	954,789	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)	6,467,758	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	13,714,621	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)	390,264	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	344,527	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	734,791	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	12,979,830	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)	1,084	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,027.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,114,103	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,367,123	22,531,831	0.060675	1,114,103	67,598	90.00
91.00	Nursing School cost	0	22,531,831	0.000000	1,114,103	0	91.00
92.00	Allied health cost	0	22,531,831	0.000000	1,114,103	0	92.00
93.00	All other Medical Education	0	22,531,831	0.000000	1,114,103	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140103 Component CCN: 14S103	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/31/2016 4:21 pm
	Title XIX	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)	11,588	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,588	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)	11,588	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)	3,005	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)	2,396	15.00
16.00	Nursery days (title V or XIX only)	1,284	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)	8,810,876	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)	8,810,876	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)	8,810,876	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)	760.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,284,822	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)	2,284,822	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140103 | Component CCN: 14S103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	689,970	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,974,792	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)	144,360	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	28,764	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	173,124	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,801,668	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: 140103 Component CCN: 14S103	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/31/2016 4:21 pm
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	556,639	8,810,876	0.063176	0	0	90.00
91.00	Nursing School cost	0	8,810,876	0.000000	0	0	91.00
92.00	Allied health cost	0	8,810,876	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,810,876	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,346,685		30.00
31.00	03100	INTENSIVE CARE UNIT		1,778,024		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.780572	120,209	93,832	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.626018	9,801	25,738	52.00
53.00	05300	ANESTHESIOLOGY	0.149917	36,740	5,508	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.302787	1,570,971	475,670	54.00
60.00	06000	LABORATORY	0.184153	5,605,062	1,032,189	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.318221	1,632,144	519,382	65.00
66.00	06600	PHYSICAL THERAPY	1.095500	151,529	166,000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.542364	2,182,754	1,183,847	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.109933	71,471	79,328	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348923	2,801,445	977,489	73.00
74.00	07400	RENAL DIALYSIS	0.242704	707,498	171,713	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3.349013	3,807	12,750	90.00
91.00	09100	EMERGENCY	0.529480	672,824	356,247	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.319271	23,722	7,574	92.00
200.00		Total (sum of lines 50-94 and 96-98)		15,589,977	5,107,267	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		15,589,977		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140103 | Component CCN: 14S103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/31/2016 4:21 pm

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		2,429,195		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.780572	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.626018	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.149917	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.302787	28,397	8,598	54.00
60.00	06000	LABORATORY	0.184153	489,823	90,202	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.318221	20,401	6,492	65.00
66.00	06600	PHYSICAL THERAPY	1.095500	4,487	4,916	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.542364	3,622	1,964	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.109933	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348923	346,470	120,891	73.00
74.00	07400	RENAL DIALYSIS	0.242704	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3.349013	163	546	90.00
91.00	09100	EMERGENCY	0.529480	130,896	69,307	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.319271	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,024,259	302,916	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,024,259		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,455,438		30.00
31.00	03100	INTENSIVE CARE UNIT		2,056,413		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		2,629,666		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.780572	1,120,176	874,378	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.626018	221,779	582,396	52.00
53.00	05300	ANESTHESIOLOGY	0.149917	107,408	16,102	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.302787	1,784,510	540,326	54.00
60.00	06000	LABORATORY	0.184153	6,124,518	1,127,848	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.318221	2,847,393	906,100	65.00
66.00	06600	PHYSICAL THERAPY	1.095500	49,930	54,698	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.542364	1,031,724	559,570	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.109933	39,103	43,402	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348923	3,738,794	1,304,551	73.00
74.00	07400	RENAL DIALYSIS	0.242704	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3.349013	51,183	171,413	90.00
91.00	09100	EMERGENCY	0.529480	541,993	286,974	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.319271	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		17,658,511	6,467,758	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		17,658,511		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140103 | Component CCN: 14S103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | 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		5,474,388		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.780572	613	478	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.626018	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.149917	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.302787	110,953	33,595	54.00
60.00	06000	LABORATORY	0.184153	866,895	159,641	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.318221	77,236	24,578	65.00
66.00	06600	PHYSICAL THERAPY	1.095500	10,220	11,196	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.542364	7,436	4,033	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.109933	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348923	880,552	307,245	73.00
74.00	07400	RENAL DIALYSIS	0.242704	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3.349013	0	0	90.00
91.00	09100	EMERGENCY	0.529480	281,793	149,204	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.319271	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,235,698	689,970	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		2,235,698		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140103	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/31/2016 4:21 pm
	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)		5,734,849		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,899,968		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)		34,407		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		1,551,611		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		155.03		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)		3.92		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).		1.06		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)		4.98		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		3.36		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)		3.36		12.00
13.00	Total allowable FTE count for the prior year.		4.01		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.		4.02		14.00
15.00	Sum of lines 12 through 14 divided by 3.		3.80		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		3.80		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.024511		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.025866		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.024511		21.00
22.00	IME payment adjustment (see instructions)		101,574		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		20,643		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)		-1.62		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)		101,574		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		20,643		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		20.69		30.00
31.00	Percentage of Medicaid patient days (see instructions)		65.79		31.00
32.00	Sum of lines 30 and 31		86.48		32.00
33.00	Allowable disproportionate share percentage (see instructions)		60.56		33.00
34.00	Disproportionate share adjustment (see instructions)		1,155,911		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A | Date/Time Prepared: 5/31/2016 4:21 pm

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			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)		0.000538391	0.000521605	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		4,117,425	3,341,476	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		3,079,607	839,933	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		3,919,540		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)		12,846,249		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)		12,866,892		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		739,476		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).		77,100		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		13,683,468		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		13,683,468		61.00
62.00	Deductibles billed to program beneficiaries		890,562		62.00
63.00	Coinsurance billed to program beneficiaries		76,545		63.00
64.00	Allowable bad debts (see instructions)		271,387		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		176,402		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		265,212		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		12,892,763		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)		-33,959		70.93
70.94	HRR adjustment amount (see instructions)		-107,848		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140103	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/31/2016 4:21 pm
	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)		12,750,956		71.00
71.01	Sequestration adjustment (see instructions)		255,019		71.01
72.00	Interim payments		12,879,509		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)		-383,572		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		106,456		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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140103	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/31/2016 4:21 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,089	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,926,887	2.00
3.00	PPS payments	1,397,983	3.00
4.00	Outlier payment (see instructions)	3,776	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)	1,089	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	3,120	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)	3,120	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	3,120	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,031	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)	1,089	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)	1,401,759	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)	308,937	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)	1,093,911	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	10,759	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)	1,104,670	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,104,670	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)	98,634	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	64,112	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	98,634	36.00
37.00	Subtotal (see instructions)	1,168,782	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)	1,168,782	40.00
40.01	Sequestration adjustment (see instructions)	23,376	40.01
41.00	Interim payments	1,170,947	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-25,541	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: 140103 Component CCN: 14S103	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/31/2016 4:21 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,745	2.00
3.00	PPS payments	1,534	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)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	1,534	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)	359	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)	1,175	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)	1,175	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,175	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)	1,175	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)	1,175	40.00
40.01	Sequestration adjustment (see instructions)	24	40.01
41.00	Interim payments	1,151	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	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: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,897,358		1,070,958	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		436,074		99,989	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/18/2015	34,091		0	3.01
3.02		02/18/2015	1,452,786		0	3.02
3.03		07/23/2015	59,200		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)		1,546,077		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)		12,879,509		1,170,947	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		383,572		25,541	6.02
7.00	Total Medicare program liability (see instructions)		12,495,937		1,145,406	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: 140103 | Component CCN: 14S103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2016 4:21 pm

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		1,611,833		1,151	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		33,040		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)		1,644,873		1,151	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		14,749		0	6.02
7.00	Total Medicare program liability (see instructions)		1,630,124		1,151	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140103	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/31/2016 4:21 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	5,825	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	5,987	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,276	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	23,825	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	177,732,910	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	7,676,866	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)	467,578	8.00
9.00	Sequestration adjustment amount (see instructions)	9,352	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	458,226	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	609,565	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)	-151,339	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140103 Component CCN: 14S103	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part II Date/Time Prepared: 5/31/2016 4:21 pm
	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)	1,862,812	1.00
2.00	Net IPF PPS Outlier Payments	2,644	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 instuctions)	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 instuctions)	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)	31.747945	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)	1,865,456	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)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,865,456	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,865,456	18.00
19.00	Deductibles	148,592	19.00
20.00	Subtotal (line 18 minus line 19)	1,716,864	20.00
21.00	Coinsurance	72,135	21.00
22.00	Subtotal (line 20 minus line 21)	1,644,729	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	28,713	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	18,663	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	28,713	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,663,392	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)	1,663,392	31.00
31.01	Sequestration adjustment (see instructions)	33,268	31.01
32.00	Interim payments	1,644,873	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)	-14,749	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	2,644	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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-3 Part VII | Date/Time Prepared: 5/31/2016 4:21 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	14,141,517		8.00
9.00	Ancillary service charges	17,658,511	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	31,800,028	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	31,800,028	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	31,800,028	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	LESS INPATIENT COSTS	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140103 Component CCN: 14S103	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2016 4:21 pm
	Title XIX	Subprovider - IPF	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	5,474,388		8.00
9.00	Ancillary service charges	2,235,698	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	7,710,086	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	7,710,086	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	7,710,086	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-4 | Date/Time Prepared: 5/31/2016 4:21 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			3.03	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			1.06	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			4.09	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			3.36	6.00
7.00	Enter the lesser of line 5 or line 6			3.36	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	2.95	2.95	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	2.95	2.95	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	0.00	2.95		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	3.77		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	4.02		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	3.58		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	0.00	3.58		17.00
18.00	Per resident amount	0.00	93,434.00		18.00
19.00	Approved amount for resident costs	0	334,494	334,494	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			334,494	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	8,206	1,276		26.00
27.00	Total Inpatient Days (see instructions)	35,413	35,413		27.00
28.00	Ratio of inpatient days to total inpatient days	0.231723	0.036032		28.00
29.00	Program direct GME amount	77,510	12,052		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		1,703		30.00
31.00	Net Program direct GME amount			87,859	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 140103	Period: From 01/01/2015 To 12/31/2015	Worksheet E-4 Date/Time Prepared: 5/31/2016 4:21 pm
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	2,057,528	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	13,828,240	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	13,828,240	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	1,929,721	42.00
43.00	Primary payer payments (see instructions)	0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	1,929,721	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	15,757,961	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.877540	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.122460	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	87,859	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	77,100	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	10,759	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/31/2016 4:21 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,999,354	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	18,349,161	0	0	0	4.00
5.00	Other receivable	280,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,531,524	0	0	0	7.00
8.00	Prepaid expenses	1,047,886	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)	26,207,925	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	54,571,278	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	54,571,278	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	659,798	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	20,406,134	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	21,065,932	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	101,845,135	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	12,006,231	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	89,301	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,561,405	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,656,937	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	24,179,483	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	24,179,483	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	38,836,420	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	63,008,715				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	63,008,715	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	101,845,135	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/31/2016 4:21 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		71,171,789		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-8,123,005				2.00
3.00	Total (sum of line 1 and line 2)		63,048,784		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	GAINS ON INVESTMENTS	0		0		0	5.00
6.00	TEMPORARILY RESTRICTED	0		0		0	6.00
7.00	CONTRIBUTIONS	0		0		0	7.00
8.00	EQUITY TRANSFER FROM SB FOUNDATION	0		0		0	8.00
9.00	ASSETS RELEASED	0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		63,048,784		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	OTHER	40,069		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		40,069		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		63,008,715		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00	GAINS ON INVESTMENTS		0			5.00
6.00	TEMPORARILY RESTRICTED		0			6.00
7.00	CONTRIBUTIONS		0			7.00
8.00	EQUITY TRANSFER FROM SB FOUNDATION		0			8.00
9.00	ASSETS RELEASED		0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	OTHER		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: 140103 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/31/2016 4:21 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	32,623,859		32,623,859	1.00
2.00	SUBPROVIDER - IPF	12,796,965		12,796,965	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)	45,420,824		45,420,824	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	6,346,933		6,346,933	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)	6,346,933		6,346,933	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	51,767,757		51,767,757	17.00
18.00	Ancillary services	64,555,914	0	64,555,914	18.00
19.00	Outpatient services	0	61,424,581	61,424,581	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	OP PHARMACY	822,657	963,352	1,786,009	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	117,146,328	62,387,933	179,534,261	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		101,702,010		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBTS	0			31.00
32.00	BP	0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		101,702,010		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140103	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prepared: 5/31/2016 4:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	179,534,261	1.00
2.00	Less contractual allowances and discounts on patients' accounts	93,899,367	2.00
3.00	Net patient revenues (line 1 minus line 2)	85,634,894	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	101,702,010	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-16,067,116	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	531,547	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	1,615	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	566,812	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	30,284	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	133,576	22.00
23.00	Governmental appropriations	0	23.00
24.00	MU/ MISCELLANEOUS INCOME	992,263	24.00
24.01	ER PRO FEE INCOME	2,505,578	24.01
24.02	ANEST PRO FEE INCOME	547,221	24.02
24.03	SISTERS MAINTENANCE	12,000	24.03
24.04	OTHER RENTAL INCOME	94,193	24.04
24.05	EMPLOYEES ROOM RENT	0	24.05
24.06	PARTNERS IN HEALTH	1,079,827	24.06
24.07	CAPITATION REVENUE	0	24.07
24.08	CLINIC REVENUE	363,061	24.08
24.09	GAIN FROM DISPOSAL	2,100	24.09
24.10	NET ASSETS RELEASED	1,084,033	24.10
25.00	Total other income (sum of lines 6-24)	7,944,110	25.00
26.00	Total (line 5 plus line 25)	-8,123,006	26.00
27.00	ROUNDING	-1	27.00
27.01		0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	-1	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-8,123,005	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140103	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/31/2016 4:21 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	610,903	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,505	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)	65.27	3.00
4.00	Number of interns & residents (see instructions)	3.80	4.00
5.00	Indirect medical education percentage (see instructions)	1.66	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)	10,141	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	20.69	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	65.79	8.00
9.00	Sum of lines 7 and 8	86.48	9.00
10.00	Allowable disproportionate share percentage (see instructions)	19.14	10.00
11.00	Disproportionate share adjustment (see instructions)	116,927	11.00
12.00	Total prospective capital payments (see instructions)	739,476	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