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: 140118	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/27/2016 2:19 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/27/2016 Time: 2:19 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 METROSOUTH MEDICAL CENTER (140118) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title 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	1,160,122	32,161	0	0	1.00
2.00	Subprovider - IPF	0	469	-53		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	1,160,591	32,108	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2016 2:16 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 12935 SOUTH GREGORY STREET	PO Box:			1.00
2.00	City: BLUE ISLAND	State: IL	Zip Code: 60406	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	METROSOUTH MEDICAL CENTER	140118	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	METRO SOUTH PSYCH UNIT	14S118	16974	4	01/01/2013	N	P	O	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)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,748	1,463	27	43	6,284	352	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: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2016 2:16 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	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.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
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: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2016 2:16 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: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2016 2:16 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	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)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	726,405	481,492	4,098,742	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2016 2:16 pm

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		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.	N	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)	0.00	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)			170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140118	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/27/2016 2:16 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: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2016 2:16 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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	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	03/21/2016	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: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2016 2:16 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				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	AMBER	WALKER	41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-221-3646	AMBER_WALKER@QUORUMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2016 2:16 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)	03/21/2016			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.		MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/27/2016 2:16 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	264	96,360	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)		264	96,360	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	36	13,140	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)		300	109,500	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	14	5,110		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)		314				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: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2016 2:16 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)	10,150	2,093	25,424			1.00
2.00	HMO and other (see instructions)	3,497	7,120				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)	10,150	2,093	25,424			7.00
8.00	INTENSIVE CARE UNIT	1,396	237	3,120			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		1,115	3,736			13.00
14.00	Total (see instructions)	11,546	3,445	32,280	0.00	632.05	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,181	0	1,663	0.00	17.44	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	649.49	27.00
28.00	Observation Bed Days		0	2,561			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	352	493			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: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2016 2:16 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	2,557	1,364	7,906	1.00
2.00	HMO and other (see instructions)			711	1,400		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	2,557	1,364	7,906	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	117	0	166	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: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/27/2016 2:16 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	44,432,999	0	44,432,999	1,350,948.00	32.89	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		695,250	0	695,250	8,712.00	79.80	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,135,461	201,494	1,336,955	42,736.00	31.28	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		324,433	0	324,433	3,703.00	87.61	11.00
12.00	Contract labor: Top level management and other management and administrative services		367,545	0	367,545	965.00	380.88	12.00
13.00	Contract labor: Physician-Part A - Administrative		593,104	0	593,104	2,623.00	226.12	13.00
14.00	Home office salaries & wage-related costs		2,472,573	0	2,472,573	40,109.00	61.65	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,442,666	0	8,442,666			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		283,444	0	283,444			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		86,840	0	86,840			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	351,277	0	351,277	9,837.00	35.71	26.00
27.00	Administrative & General	5.00	4,680,530	-472,485	4,208,045	159,006.00	26.46	27.00
28.00	Administrative & General under contract (see inst.)		996,647	0	996,647	21,747.25	45.83	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,226,700	0	1,226,700	31,406.00	39.06	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		2,679,137	0	2,679,137	135,161.00	19.82	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,897,024	0	1,897,024	83,709.00	22.66	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,733,489	270,991	2,004,480	45,203.00	44.34	38.00
39.00	Central Services and Supply	14.00	784,600	0	784,600	32,089.00	24.45	39.00
40.00	Pharmacy	15.00	1,741,800	0	1,741,800	40,817.60	42.67	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/27/2016 2:16 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	729,727	0	729,727	30,117.00	24.23	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part III Date/Time Prepared: 5/27/2016 2:16 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)		49,310,557	0	49,310,557	1,582,853.25	31.15	1.00
2.00	Excluded area salaries (see instructions)		1,135,461	201,494	1,336,955	42,736.00	31.28	2.00
3.00	Subtotal salaries (line 1 minus line 2)		48,175,096	-201,494	47,973,602	1,540,117.25	31.15	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,757,655	0	3,757,655	47,400.00	79.28	4.00
5.00	Subtotal wage-related costs (see inst.)		8,442,666	0	8,442,666	0.00	17.60	5.00
6.00	Total (sum of lines 3 thru 5)		60,375,417	-201,494	60,173,923	1,587,517.25	37.90	6.00
7.00	Total overhead cost (see instructions)		16,820,931	-201,494	16,619,437	589,092.85	28.21	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 5/27/2016 2:16 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	898,605	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,568,957	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	169,845	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	33,721	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	3,756	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	131,329	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	595,841	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,463,375	17.00
18.00	Medicare Taxes - Employers Portion Only	576,112	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	318,273	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,759,814	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER - EMPLOYEE RELOCATION	53,135	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part V | Date/Time Prepared: 5/27/2016 2:16 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	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-10 | Date/Time Prepared: 5/27/2016 2:16 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)	0.160608	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	16,080,920	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	17,579,725	5.00
6.00	Medicaid charges	179,612,588	6.00
7.00	Medicaid cost (line 1 times line 6)	28,847,219	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	177,198	9.00
10.00	Stand-alone SCHIP charges	2,198,870	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	353,156	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	175,958	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)	175,958	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	1,244,816	32,478	1,277,294	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	199,927	5,216	205,143	21.00
22.00	Partial payment by patients approved for charity care	375	2,563	2,938	22.00
23.00	Cost of charity care (line 21 minus line 22)	199,552	2,653	202,205	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	14,699,787	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	795,573	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	13,904,214	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,233,128	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,435,333	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,611,291	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/27/2016 2:16 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		1,850,371	1,850,371	54,606	1,904,977	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,715,111	6,715,111	1,185,037	7,900,148	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	351,277	149,582	500,859	5,410,625	5,911,484	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,680,530	52,152,437	56,832,967	-6,310,860	50,522,107	5.00
7.00	00700	OPERATION OF PLANT	1,226,700	4,339,706	5,566,406	-3,091	5,563,315	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	984,252	984,252	0	984,252	8.00
9.00	00900	HOUSEKEEPING	0	3,248,317	3,248,317	0	3,248,317	9.00
10.00	01000	DIETARY	0	2,641,651	2,641,651	-1,460	2,640,191	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,733,489	251,788	1,985,277	270,991	2,256,268	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	784,600	7,520,935	8,305,535	-6,688,594	1,616,941	14.00
15.00	01500	PHARMACY	1,741,800	3,585,826	5,327,626	-2,631,404	2,696,222	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	729,727	1,418,773	2,148,500	0	2,148,500	16.00
17.00	01700	SOCIAL SERVICE	0	55	55	-55	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,626,310	3,716,425	12,342,735	-1,440	12,341,295	30.00
31.00	03100	INTENSIVE CARE UNIT	2,676,759	510,842	3,187,601	0	3,187,601	31.00
40.00	04000	SUBPROVIDER - IPF	1,083,680	210,000	1,293,680	0	1,293,680	40.00
43.00	04300	NURSERY	897,992	741,757	1,639,749	-6,048	1,633,701	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,301,696	3,562,088	6,863,784	-1,017,849	5,845,935	50.00
51.00	05100	RECOVERY ROOM	687,910	74,634	762,544	0	762,544	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,545,937	418,938	2,964,875	-637	2,964,238	52.00
53.00	05300	ANESTHESIOLOGY	56,947	820,584	877,531	0	877,531	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,669,154	1,086,104	2,755,258	0	2,755,258	54.00
54.01	05401	ULTRASOUND	494,155	77,508	571,663	0	571,663	54.01
56.00	05600	RADIOISOTOPE	230,477	340,169	570,646	0	570,646	56.00
57.00	05700	CT SCAN	665,298	295,984	961,282	0	961,282	57.00
58.00	05800	MRI	206,527	129,257	335,784	0	335,784	58.00
60.00	06000	LABORATORY	2,326,296	2,518,989	4,845,285	-17,625	4,827,660	60.00
65.00	06500	RESPIRATORY THERAPY	943,155	305,606	1,248,761	-96,307	1,152,454	65.00
66.00	06600	PHYSICAL THERAPY	672,269	94,571	766,840	-139,120	627,720	66.00
67.00	06700	OCCUPATIONAL THERAPY	82,389	7,446	89,835	10,583	100,418	67.00
68.00	06800	SPEECH PATHOLOGY	181,327	30,531	211,858	112,798	324,656	68.00
69.00	06900	ELECTROCARDIOLOGY	2,143,317	2,209,982	4,353,299	-1,407,247	2,946,052	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,688,733	3,688,733	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,623,803	4,623,803	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,397,277	2,397,277	73.00
74.00	07400	RENAL DIALYSIS	0	485,212	485,212	0	485,212	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	117,245	16,064	133,309	0	133,309	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,219	12,339	18,558	0	18,558	90.00
91.00	09100	EMERGENCY	3,518,036	1,144,751	4,662,787	0	4,662,787	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	44,381,218	103,668,585	148,049,803	-567,284	147,482,519	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-1,823	-1,823	0	-1,823	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,089	91	4,180	0	4,180	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	567,284	567,284	194.01
194.02	07953	SENIOR CIRCLE	47,692	17,273	64,965	0	64,965	194.02
194.03	07952	MOB	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	44,432,999	103,684,126	148,117,125	0	148,117,125	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/27/2016 2:16 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	-1,794,006	110,971		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-3,427,467	4,472,681		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-11,865	5,899,619		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-34,937,677	15,584,430		5.00
7.00	00700	OPERATION OF PLANT	0	5,563,315		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	984,252		8.00
9.00	00900	HOUSEKEEPING	0	3,248,317		9.00
10.00	01000	DIETARY	-154,947	2,485,244		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	-7,018	2,249,250		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,616,941		14.00
15.00	01500	PHARMACY	0	2,696,222		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,009	2,147,491		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,968,978	10,372,317		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,187,601		31.00
40.00	04000	SUBPROVIDER - IPF	0	1,293,680		40.00
43.00	04300	NURSERY	-560,500	1,073,201		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	5,845,935		50.00
51.00	05100	RECOVERY ROOM	0	762,544		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,964,238		52.00
53.00	05300	ANESTHESIOLOGY	-612,000	265,531		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,755,258		54.00
54.01	05401	ULTRASOUND	0	571,663		54.01
56.00	05600	RADIOISOTOPE	0	570,646		56.00
57.00	05700	CT SCAN	0	961,282		57.00
58.00	05800	MRI	0	335,784		58.00
60.00	06000	LABORATORY	0	4,827,660		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,152,454		65.00
66.00	06600	PHYSICAL THERAPY	0	627,720		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	100,418		67.00
68.00	06800	SPEECH PATHOLOGY	0	324,656		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,946,052		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,688,733		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,623,803		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-78	2,397,199		73.00
74.00	07400	RENAL DIALYSIS	0	485,212		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	133,309		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	18,558		90.00
91.00	09100	EMERGENCY	-89,024	4,573,763		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-43,564,569	103,917,950		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-1,823		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,180		192.00
194.00	07950	CHF CLINIC	0	0		194.00
194.01	07951	MARKETING	0	567,284		194.01
194.02	07953	SENIOR CIRCLE	0	64,965		194.02
194.03	07952	MOB	0	0		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-43,564,569	104,552,556		200.00

RECLASSIFICATIONS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/27/2016 2:16 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,410,625	1.00
2.00		0.00	0	0	2.00
	0		0	5,410,625	
	B - OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	86,664	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	86,664	
	C - RENTAL AND LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	463,985	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,175,420	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
	0		0	1,639,405	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	240,282	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	399,762	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,617	3.00
4.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1	4.00
	0		0	649,662	
	E - MARKETING DEPARTMENT				
1.00	MARKETING	194.01	201,494	365,790	1.00
	0		201,494	365,790	
	F - CHIEF NURSING OFFICER				
1.00	NURSING ADMINISTRATION	13.00	270,991	0	1.00
	0		270,991	0	
	G - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,602,069	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,623,803	2.00
3.00		0.00	0	0	3.00
	0		0	8,225,872	
	H - COSTS OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,397,277	1.00
	0		0	2,397,277	
	I - PT, OT, SP COSTS				
1.00	OCCUPATIONAL THERAPY	67.00	5,653	4,930	1.00
2.00	SPEECH PATHOLOGY	68.00	102,459	10,339	2.00
	0		108,112	15,269	
	J - MISCELLANEOUS DEPARTMENT				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	55	1.00
	TOTALS		0	55	
500.00	Grand Total: Increases		580,597	18,790,619	500.00

RECLASSIFICATIONS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/27/2016 2:16 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,409,215	0		1.00
2.00	LABORATORY	60.00	0	1,410	0		2.00
	0		0	5,410,625			
	B - OXYGEN COSTS						
1.00	OPERATION OF PLANT	7.00	0	209	0		1.00
2.00	OPERATING ROOM	50.00	0	12	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	86,443	0		3.00
	0		0	86,664			
	C - RENTAL AND LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	463,187	10		1.00
2.00	OPERATION OF PLANT	7.00	0	2,882	10		2.00
3.00	DIETARY	10.00	0	1,460	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	410,527	0		4.00
5.00	PHARMACY	15.00	0	234,127	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	1,440	0		6.00
7.00	NURSERY	43.00	0	6,048	0		7.00
8.00	OPERATING ROOM	50.00	0	465,490	0		8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	637	0		9.00
10.00	LABORATORY	60.00	0	16,215	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	9,864	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	15,739	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	11,789	0		13.00
	0		0	1,639,405			
	D - OTHER CAPITAL COSTS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1	12		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	649,661	13		2.00
3.00		0.00	0	0	12		3.00
4.00		0.00	0	0	12		4.00
	0		0	649,662			
	E - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	201,494	365,790	0		1.00
	0		201,494	365,790			
	F - CHIEF NURSING OFFICER						
1.00	ADMINISTRATIVE & GENERAL	5.00	270,991	0	0		1.00
	0		270,991	0			
	G - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	6,278,067	0		1.00
2.00	OPERATING ROOM	50.00	0	552,347	0		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	1,395,458	0		3.00
	0		0	8,225,872			
	H - COSTS OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	2,397,277	0		1.00
	0		0	2,397,277			
	I - PT, OT, SP COSTS						
1.00	PHYSICAL THERAPY	66.00	108,112	15,269	0		1.00
2.00		0.00	0	0	0		2.00
	0		108,112	15,269			
	J - MISCELLANEOUS DEPARTMENT						
1.00	SOCIAL SERVICE	17.00	0	55	0		1.00
	TOTALS		0	55			
500.00	Grand Total: Decreases		580,597	18,790,619			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/27/2016 2:16 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	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	634,099	42,242	0	42,242	8,926	3.00
4.00	Building Improvements	17,811,874	308,355	0	308,355	2,895,800	4.00
5.00	Fixed Equipment	1,274,213	104,529	0	104,529	0	5.00
6.00	Movable Equipment	10,700,253	1,807,713	0	1,807,713	0	6.00
7.00	HIT designated Assets	13,684,985	61,671	0	61,671	0	7.00
8.00	Subtotal (sum of lines 1-7)	44,105,424	2,324,510	0	2,324,510	2,904,726	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	44,105,424	2,324,510	0	2,324,510	2,904,726	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	667,415	0	3.00
4.00	Building Improvements	15,224,429	0	4.00
5.00	Fixed Equipment	1,378,742	0	5.00
6.00	Movable Equipment	12,507,966	0	6.00
7.00	HIT designated Assets	13,746,656	0	7.00
8.00	Subtotal (sum of lines 1-7)	43,525,208	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	43,525,208	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/27/2016 2:16 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	1,850,371	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,524,000	191,111	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,374,371	191,111	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,850,371	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,715,111	2.00
3.00	Total (sum of lines 1-2)	0	8,565,482	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/27/2016 2:16 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	15,891,843	0	15,891,843	0.365118	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	27,633,363	0	27,633,363	0.634882	0	2.00
3.00	Total (sum of lines 1-2)	43,525,206	0	43,525,206	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	610,696	-90,346	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,873,587	1,589,477	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,484,283	1,499,131	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	240,282	-649,661	0	110,971	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,617	0	0	4,472,681	2.00
3.00	Total (sum of lines 1-2)	0	249,899	-649,661	0	4,583,652	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/27/2016 2:16 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)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-153,334	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-25,768	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,241,224			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	-11,587,259			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-154,947	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	-1,009	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-7,446	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-1,239,675	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-3,625,875	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PHARMACY REVENUE	B	-78	DRUGS CHARGED TO PATIENTS	73.00	0	33.00
33.01	A&G OTHER INCOME	B	-247,967	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/27/2016 2:16 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	
33.02	RENTAL INCOME	B	-607,218	CAP REL COSTS-BLDG & FIXT	1.00	10	33.02
33.03	HOSPITAL BAD DEBT	A	-14,699,787	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PATIENT TELEPHONE COSTS - BENEFITS	A	-8,928	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MARKETING EXPENSE	A	-156,698	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	LOBBYING EXPENSE	A	-74,151	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PROVIDER TAX	A	-7,446,522	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	PHYSICIAN RECRUITING	A	-169,167	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	PATIENT TELEPHONE & TV DEPRECIATION	A	-24,538	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.10	SPECIAL EVENTS	A	-615	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	CON COSTS	A	-3,040	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	MARKETING EXPENSE	A	-2,937	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13			0		0.00	0	33.13
33.34	CHARITABLE CONTRIBUTIONS	A	-1,799	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	OTHER NON-ALLOWABLE COST	A	-84,587	ADMINISTRATIVE & GENERAL	5.00	0	33.35
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-43,564,569				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 5/27/2016 2:16 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO CAPITAL COSTS - BLDG & FI	52,887	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO CAPITAL COSTS - MOVABLE E	222,946	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HO COSTS	3,447,681	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	6,751,814	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	CIG LEASED EXPENSE	146,547	191,112	4.01
4.04	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	4,830,282	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	4,277	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	60,300	4.06
4.13	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	24,420	4.13
4.17	5.00	ADMINISTRATIVE & GENERAL	PASI COLLECTION FEES	0	624,319	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	EBOS FEES	0	75,650	4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE ALLOCATIONS	1,203,596	4,098,742	4.19
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,073,657	16,660,916	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 5/27/2016 2:16 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	52,887	10		1.00
2.00	222,946	10		2.00
3.00	3,447,681	0		3.00
4.00	-6,751,814	0		4.00
4.01	-44,565	0		4.01
4.04	-4,830,282	0		4.04
4.05	-4,277	0		4.05
4.06	-60,300	0		4.06
4.13	-24,420	0		4.13
4.17	-624,319	0		4.17
4.18	-75,650	0		4.18
4.19	-2,895,146	0		4.19
5.00	-11,587,259			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/27/2016 2:16 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	64,020	0	64,020	177,200	708	1.00
2.00	13.00	NURSING ADMINISTRATION	39,050	0	39,050	177,200	376	2.00
3.00	30.00	ADULTS & PEDIATRICS	1,968,978	1,968,978	0	0	0	3.00
4.00	43.00	NURSERY	560,500	560,500	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	612,000	612,000	0	0	0	5.00
6.00	91.00	EMERGENCY	89,024	89,024	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,333,572	3,230,502	103,070		1,084	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	60,316	3,016	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	32,032	1,602	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	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	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			92,348	4,618	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	60,316	3,704	3,704		1.00
2.00	13.00	NURSING ADMINISTRATION	0	32,032	7,018	7,018		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,968,978		3.00
4.00	43.00	NURSERY	0	0	0	560,500		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	612,000		5.00
6.00	91.00	EMERGENCY	0	0	0	89,024		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	92,348	10,722	3,241,224		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/27/2016 2:16 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	110,971	110,971				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,472,681		4,472,681			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,899,619	0	0	5,899,619		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,584,430	16,017	645,558	563,179	16,809,184	5.00
7.00	00700	OPERATION OF PLANT	5,563,315	13,173	530,916	164,174	6,271,578	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	984,252	2,717	109,524	0	1,096,493	8.00
9.00	00900	HOUSEKEEPING	3,248,317	0	0	0	3,248,317	9.00
10.00	01000	DIETARY	2,485,244	0	0	0	2,485,244	10.00
11.00	01100	CAFETERIA	0	5,351	215,660	0	221,011	11.00
13.00	01300	NURSING ADMINISTRATION	2,249,250	0	0	268,268	2,517,518	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,616,941	1,298	52,314	105,006	1,775,559	14.00
15.00	01500	PHARMACY	2,696,222	810	32,662	233,112	2,962,806	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,147,491	913	36,800	97,662	2,282,866	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,372,317	17,442	702,960	1,154,482	12,247,201	30.00
31.00	03100	INTENSIVE CARE UNIT	3,187,601	3,070	123,752	358,241	3,672,664	31.00
40.00	04000	SUBPROVIDER - IPF	1,293,680	0	0	145,033	1,438,713	40.00
43.00	04300	NURSERY	1,073,201	1,141	45,996	120,182	1,240,520	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,845,935	9,575	385,911	441,879	6,683,300	50.00
51.00	05100	RECOVERY ROOM	762,544	1,099	44,276	92,066	899,985	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,964,238	1,819	73,320	340,733	3,380,110	52.00
53.00	05300	ANESTHESIOLOGY	265,531	0	0	7,621	273,152	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,755,258	3,457	139,334	223,390	3,121,439	54.00
54.01	05401	ULTRASOUND	571,663	0	0	66,135	637,798	54.01
56.00	05600	RADIOISOTOPE	570,646	594	23,943	30,846	626,029	56.00
57.00	05700	CT SCAN	961,282	1,151	46,397	89,039	1,097,869	57.00
58.00	05800	MRI	335,784	220	8,855	27,640	372,499	58.00
60.00	06000	LABORATORY	4,827,660	3,418	137,768	311,337	5,280,183	60.00
65.00	06500	RESPIRATORY THERAPY	1,152,454	840	33,863	126,226	1,313,383	65.00
66.00	06600	PHYSICAL THERAPY	627,720	2,360	95,126	75,503	800,709	66.00
67.00	06700	OCCUPATIONAL THERAPY	100,418	0	0	11,783	112,201	67.00
68.00	06800	SPEECH PATHOLOGY	324,656	0	0	37,980	362,636	68.00
69.00	06900	ELECTROCARDIOLOGY	2,946,052	10,659	429,609	286,849	3,673,169	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,688,733	0	0	0	3,688,733	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,623,803	0	0	0	4,623,803	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,397,199	0	0	0	2,397,199	73.00
74.00	07400	RENAL DIALYSIS	485,212	0	0	0	485,212	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	133,309	725	29,222	15,691	178,947	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	18,558	456	18,392	832	38,238	90.00
91.00	09100	EMERGENCY	4,573,763	4,957	199,780	470,833	5,249,333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	103,917,950	103,262	4,161,938	5,865,722	103,565,601	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-1,823	492	19,839	0	18,508	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,180	1,126	45,400	547	51,253	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	567,284	0	0	26,967	594,251	194.01
194.02	07953	SENIOR CIRCLE	64,965	0	0	6,383	71,348	194.02
194.03	07952	MOB	0	6,091	245,504	0	251,595	194.03
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)	104,552,556	110,971	4,472,681	5,899,619	104,552,556	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/27/2016 2:16 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,809,184					5.00
7.00	00700	OPERATION OF PLANT	1,201,459	7,473,037				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	210,057	248,310	1,554,860			8.00
9.00	00900	HOUSEKEEPING	622,287	0	0	3,870,604		9.00
10.00	01000	DIETARY	476,103	0	0	0	2,961,347	10.00
11.00	01100	CAFETERIA	42,340	488,936	9,134	261,945	1,209,306	11.00
13.00	01300	NURSING ADMINISTRATION	482,286	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	340,147	118,605	0	63,542	0	14.00
15.00	01500	PHARMACY	567,591	74,051	0	39,672	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	437,333	83,433	0	44,699	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,346,233	1,593,714	342,996	853,822	1,063,613	30.00
31.00	03100	INTENSIVE CARE UNIT	703,580	280,567	105,131	150,312	85,019	31.00
40.00	04000	SUBPROVIDER - IPF	275,617	0	0	0	71,945	40.00
43.00	04300	NURSERY	237,649	104,281	4,525	55,868	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,280,333	874,924	285,758	468,735	0	50.00
51.00	05100	RECOVERY ROOM	172,412	100,382	39,381	53,779	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	647,534	166,228	107,238	89,056	0	52.00
53.00	05300	ANESTHESIOLOGY	52,328	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	597,980	315,894	148,599	169,238	0	54.00
54.01	05401	ULTRASOUND	122,184	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	119,930	54,283	14,384	29,082	0	56.00
57.00	05700	CT SCAN	210,321	105,189	0	56,354	0	57.00
58.00	05800	MRI	71,360	20,076	0	10,756	0	58.00
60.00	06000	LABORATORY	1,011,535	312,342	0	167,335	0	60.00
65.00	06500	RESPIRATORY THERAPY	251,607	76,773	10,852	41,131	0	65.00
66.00	06600	PHYSICAL THERAPY	153,393	215,666	38,847	115,542	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,495	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	69,471	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	703,676	973,993	113,435	521,811	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	706,658	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	885,791	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	459,236	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	92,953	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	34,281	66,252	4,588	35,494	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,325	41,697	4,477	22,339	0	90.00
91.00	09100	EMERGENCY	1,005,625	452,934	280,933	242,657	52,880	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,620,110	6,768,530	1,510,278	3,493,169	2,482,763	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,546	44,979	0	24,097	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,819	102,930	11,061	55,144	439,108	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	113,842	0	0	0	0	194.01
194.02	07953	SENIOR CIRCLE	13,668	0	0	0	39,476	194.02
194.03	07952	MOB	48,199	556,598	33,521	298,194	0	194.03
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)	16,809,184	7,473,037	1,554,860	3,870,604	2,961,347	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/27/2016 2:16 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,232,672					11.00
13.00	01300	NURSING ADMINISTRATION	87,728	3,087,532				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	62,293	0	2,360,146			14.00
15.00	01500	PHARMACY	79,209	0	128,935	3,852,264		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	58,458	0	1,041	0	2,907,830	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	563,302	1,001,081	123,619	0	254,195	30.00
31.00	03100	INTENSIVE CARE UNIT	138,596	310,638	40,219	0	50,031	31.00
40.00	04000	SUBPROVIDER - IPF	70,408	125,761	4,431	0	13,690	40.00
43.00	04300	NURSERY	44,167	104,212	11,070	0	47,459	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	169,843	383,162	63,091	0	584,836	50.00
51.00	05100	RECOVERY ROOM	28,906	79,832	2,950	0	36,311	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	110,538	295,456	30,501	0	40,710	52.00
53.00	05300	ANESTHESIOLOGY	5,814	6,609	28,754	0	68,678	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,796	0	28,245	0	103,838	54.00
54.01	05401	ULTRASOUND	22,326	0	2,191	0	44,333	54.01
56.00	05600	RADIOISOTOPE	8,680	0	924	0	24,143	56.00
57.00	05700	CT SCAN	31,692	0	11,740	0	175,941	57.00
58.00	05800	MRI	8,922	0	2,676	0	37,750	58.00
60.00	06000	LABORATORY	157,369	0	207,735	0	409,006	60.00
65.00	06500	RESPIRATORY THERAPY	57,933	109,453	19,007	0	42,643	65.00
66.00	06600	PHYSICAL THERAPY	30,642	0	2,490	0	18,769	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,764	0	22	0	2,929	67.00
68.00	06800	SPEECH PATHOLOGY	16,431	0	121	0	8,291	68.00
69.00	06900	ELECTROCARDIOLOGY	140,655	248,732	88,237	0	177,230	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	718,264	0	43,947	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	722,024	0	183,798	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,852,264	184,909	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,605	0	14,454	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	9,205	13,606	829	0	6,658	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	283	722	940	0	1,169	90.00
91.00	09100	EMERGENCY	221,923	408,268	118,223	0	332,112	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,220,883	3,087,532	2,359,884	3,852,264	2,907,830	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	565	0	76	0	0	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	7,348	0	0	0	0	194.01
194.02	07953	SENIOR CIRCLE	3,876	0	186	0	0	194.02
194.03	07952	MOB	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,232,672	3,087,532	2,360,146	3,852,264	2,907,830	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/27/2016 2:16 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	20,389,776	0	20,389,776		30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,536,757	0	5,536,757		31.00
40.00	04000	SUBPROVIDER - IPF	0	2,000,565	0	2,000,565		40.00
43.00	04300	NURSERY	0	1,849,751	0	1,849,751		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,793,982	0	10,793,982		50.00
51.00	05100	RECOVERY ROOM	0	1,413,938	0	1,413,938		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,867,371	0	4,867,371		52.00
53.00	05300	ANESTHESIOLOGY	0	435,335	0	435,335		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,576,029	0	4,576,029		54.00
54.01	05401	ULTRASOUND	0	828,832	0	828,832		54.01
56.00	05600	RADIOISOTOPE	0	877,455	0	877,455		56.00
57.00	05700	CT SCAN	0	1,689,106	0	1,689,106		57.00
58.00	05800	MRI	0	524,039	0	524,039		58.00
60.00	06000	LABORATORY	0	7,545,505	0	7,545,505		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,922,782	0	1,922,782		65.00
66.00	06600	PHYSICAL THERAPY	0	1,376,058	0	1,376,058		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	141,411	0	141,411		67.00
68.00	06800	SPEECH PATHOLOGY	0	456,950	0	456,950		68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,640,938	0	6,640,938		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,157,602	0	5,157,602		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,415,416	0	6,415,416		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,893,608	0	6,893,608		73.00
74.00	07400	RENAL DIALYSIS	0	594,224	0	594,224		74.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	349,860	0	349,860		76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	117,190	0	117,190		90.00
91.00	09100	EMERGENCY	0	8,364,888	0	8,364,888		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	101,759,368	0	101,759,368		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	91,130	0	91,130		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	669,956	0	669,956		192.00
194.00	07950	CHF CLINIC	0	0	0	0		194.00
194.01	07951	MARKETING	0	715,441	0	715,441		194.01
194.02	07953	SENIOR CIRCLE	0	128,554	0	128,554		194.02
194.03	07952	MOB	0	1,188,107	0	1,188,107		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	104,552,556	0	104,552,556		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/27/2016 2:16 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	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	16,017	645,558	661,575	0	5.00
7.00	00700	OPERATION OF PLANT	0	13,173	530,916	544,089	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,717	109,524	112,241	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	5,351	215,660	221,011	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,298	52,314	53,612	0	14.00
15.00	01500	PHARMACY	0	810	32,662	33,472	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	913	36,800	37,713	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	17,442	702,960	720,402	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,070	123,752	126,822	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	1,141	45,996	47,137	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,575	385,911	395,486	0	50.00
51.00	05100	RECOVERY ROOM	0	1,099	44,276	45,375	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,819	73,320	75,139	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,457	139,334	142,791	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	594	23,943	24,537	0	56.00
57.00	05700	CT SCAN	0	1,151	46,397	47,548	0	57.00
58.00	05800	MRI	0	220	8,855	9,075	0	58.00
60.00	06000	LABORATORY	0	3,418	137,768	141,186	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	840	33,863	34,703	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,360	95,126	97,486	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,659	429,609	440,268	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	725	29,222	29,947	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	456	18,392	18,848	0	90.00
91.00	09100	EMERGENCY	0	4,957	199,780	204,737	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	103,262	4,161,938	4,265,200	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	492	19,839	20,331	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,126	45,400	46,526	0	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07953	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07952	MOB	0	6,091	245,504	251,595	0	194.03
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	110,971	4,472,681	4,583,652	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/27/2016 2:16 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	661,575					5.00
7.00	00700	OPERATION OF PLANT	47,288	591,377				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,268	19,650	140,159			8.00
9.00	00900	HOUSEKEEPING	24,492	0	0	24,492		9.00
10.00	01000	DIETARY	18,739	0	0	0	18,739	10.00
11.00	01100	CAFETERIA	1,666	38,692	823	1,658	7,652	11.00
13.00	01300	NURSING ADMINISTRATION	18,982	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,388	9,386	0	402	0	14.00
15.00	01500	PHARMACY	22,340	5,860	0	251	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,213	6,602	0	283	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	92,332	126,118	30,917	5,402	6,730	30.00
31.00	03100	INTENSIVE CARE UNIT	27,692	22,203	9,477	951	538	31.00
40.00	04000	SUBPROVIDER - IPF	10,848	0	0	0	455	40.00
43.00	04300	NURSERY	9,354	8,252	408	354	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,392	69,237	25,759	2,966	0	50.00
51.00	05100	RECOVERY ROOM	6,786	7,944	3,550	340	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,486	13,154	9,667	564	0	52.00
53.00	05300	ANESTHESIOLOGY	2,060	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,536	24,998	13,395	1,071	0	54.00
54.01	05401	ULTRASOUND	4,809	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	4,720	4,296	1,297	184	0	56.00
57.00	05700	CT SCAN	8,278	8,324	0	357	0	57.00
58.00	05800	MRI	2,809	1,589	0	68	0	58.00
60.00	06000	LABORATORY	39,813	24,717	0	1,059	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,903	6,075	978	260	0	65.00
66.00	06600	PHYSICAL THERAPY	6,037	17,067	3,502	731	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	846	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,734	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	27,696	77,077	10,225	3,302	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,813	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,863	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,075	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,658	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,349	5,243	414	225	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	288	3,300	404	141	0	90.00
91.00	09100	EMERGENCY	39,580	35,843	25,324	1,535	335	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	654,133	535,627	136,140	22,104	15,710	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	140	3,559	0	152	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	386	8,145	997	349	2,779	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	4,481	0	0	0	0	194.01
194.02	07953	SENIOR CIRCLE	538	0	0	0	250	194.02
194.03	07952	MOB	1,897	44,046	3,022	1,887	0	194.03
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)	661,575	591,377	140,159	24,492	18,739	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/27/2016 2:16 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	271,502					11.00
13.00	01300	NURSING ADMINISTRATION	10,668	29,650				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,575	0	84,363			14.00
15.00	01500	PHARMACY	9,632	0	4,609	76,164		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,109	0	37	0	68,957	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	68,499	9,622	4,419	0	6,038	30.00
31.00	03100	INTENSIVE CARE UNIT	16,854	2,982	1,438	0	1,188	31.00
40.00	04000	SUBPROVIDER - IPF	8,562	1,207	158	0	325	40.00
43.00	04300	NURSERY	5,371	1,000	396	0	1,127	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,654	3,678	2,255	0	13,781	50.00
51.00	05100	RECOVERY ROOM	3,515	766	105	0	862	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,442	2,836	1,090	0	967	52.00
53.00	05300	ANESTHESIOLOGY	707	63	1,028	0	1,631	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,041	0	1,010	0	2,466	54.00
54.01	05401	ULTRASOUND	2,715	0	78	0	1,053	54.01
56.00	05600	RADIOISOTOPE	1,056	0	33	0	573	56.00
57.00	05700	CT SCAN	3,854	0	420	0	4,179	57.00
58.00	05800	MRI	1,085	0	96	0	897	58.00
60.00	06000	LABORATORY	19,137	0	7,426	0	9,715	60.00
65.00	06500	RESPIRATORY THERAPY	7,045	1,051	679	0	1,013	65.00
66.00	06600	PHYSICAL THERAPY	3,726	0	89	0	446	66.00
67.00	06700	OCCUPATIONAL THERAPY	579	0	1	0	70	67.00
68.00	06800	SPEECH PATHOLOGY	1,998	0	4	0	197	68.00
69.00	06900	ELECTROCARDIOLOGY	17,104	2,388	3,154	0	4,210	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	25,676	0	1,044	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	25,805	0	4,366	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	76,164	4,392	73.00
74.00	07400	RENAL DIALYSIS	0	0	57	0	343	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,119	131	30	0	158	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	34	7	34	0	28	90.00
91.00	09100	EMERGENCY	26,987	3,919	4,226	0	7,888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	270,068	29,650	84,353	76,164	68,957	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	69	0	3	0	0	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	894	0	0	0	0	194.01
194.02	07953	SENIOR CIRCLE	471	0	7	0	0	194.02
194.03	07952	MOB	0	0	0	0	0	194.03
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)	271,502	29,650	84,363	76,164	68,957	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/27/2016 2:16 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,070,479	0	1,070,479		30.00
31.00	03100	INTENSIVE CARE UNIT	0	210,145	0	210,145		31.00
40.00	04000	SUBPROVIDER - IPF	0	21,555	0	21,555		40.00
43.00	04300	NURSERY	0	73,399	0	73,399		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	584,208	0	584,208		50.00
51.00	05100	RECOVERY ROOM	0	69,243	0	69,243		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	142,345	0	142,345		52.00
53.00	05300	ANESTHESIOLOGY	0	5,489	0	5,489		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	220,308	0	220,308		54.00
54.01	05401	ULTRASOUND	0	8,655	0	8,655		54.01
56.00	05600	RADIOISOTOPE	0	36,696	0	36,696		56.00
57.00	05700	CT SCAN	0	72,960	0	72,960		57.00
58.00	05800	MRI	0	15,619	0	15,619		58.00
60.00	06000	LABORATORY	0	243,053	0	243,053		60.00
65.00	06500	RESPIRATORY THERAPY	0	61,707	0	61,707		65.00
66.00	06600	PHYSICAL THERAPY	0	129,084	0	129,084		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,496	0	1,496		67.00
68.00	06800	SPEECH PATHOLOGY	0	4,933	0	4,933		68.00
69.00	06900	ELECTROCARDIOLOGY	0	585,424	0	585,424		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	54,533	0	54,533		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	65,034	0	65,034		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	98,631	0	98,631		73.00
74.00	07400	RENAL DIALYSIS	0	4,058	0	4,058		74.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	38,616	0	38,616		76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	23,084	0	23,084		90.00
91.00	09100	EMERGENCY	0	350,374	0	350,374		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,191,128	0	4,191,128		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,182	0	24,182		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	59,254	0	59,254		192.00
194.00	07950	CHF CLINIC	0	0	0	0		194.00
194.01	07951	MARKETING	0	5,375	0	5,375		194.01
194.02	07953	SENIOR CIRCLE	0	1,266	0	1,266		194.02
194.03	07952	MOB	0	302,447	0	302,447		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	4,583,652	0	4,583,652		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/27/2016 2:16 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	525,290					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		525,290				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	44,081,722			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	75,817	75,817	4,208,045	-16,809,184	87,743,372	5.00
7.00	00700	OPERATION OF PLANT	62,353	62,353	1,226,700	0	6,271,578	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,863	12,863	0	0	1,096,493	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	3,248,317	9.00
10.00	01000	DIETARY	0	0	0	0	2,485,244	10.00
11.00	01100	CAFETERIA	25,328	25,328	0	0	221,011	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,004,480	0	2,517,518	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,144	6,144	784,600	0	1,775,559	14.00
15.00	01500	PHARMACY	3,836	3,836	1,741,800	0	2,962,806	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,322	4,322	729,727	0	2,282,866	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	82,558	82,558	8,626,310	0	12,247,201	30.00
31.00	03100	INTENSIVE CARE UNIT	14,534	14,534	2,676,759	0	3,672,664	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	1,083,680	0	1,438,713	40.00
43.00	04300	NURSERY	5,402	5,402	897,992	0	1,240,520	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,323	45,323	3,301,696	0	6,683,300	50.00
51.00	05100	RECOVERY ROOM	5,200	5,200	687,910	0	899,985	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,611	8,611	2,545,937	0	3,380,110	52.00
53.00	05300	ANESTHESIOLOGY	0	0	56,947	0	273,152	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,364	16,364	1,669,154	0	3,121,439	54.00
54.01	05401	ULTRASOUND	0	0	494,155	0	637,798	54.01
56.00	05600	RADIOISOTOPE	2,812	2,812	230,477	0	626,029	56.00
57.00	05700	CT SCAN	5,449	5,449	665,298	0	1,097,869	57.00
58.00	05800	MRI	1,040	1,040	206,527	0	372,499	58.00
60.00	06000	LABORATORY	16,180	16,180	2,326,296	0	5,280,183	60.00
65.00	06500	RESPIRATORY THERAPY	3,977	3,977	943,155	0	1,313,383	65.00
66.00	06600	PHYSICAL THERAPY	11,172	11,172	564,157	0	800,709	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	88,042	0	112,201	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	283,786	0	362,636	68.00
69.00	06900	ELECTROCARDIOLOGY	50,455	50,455	2,143,317	0	3,673,169	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,688,733	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,623,803	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,397,199	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	485,212	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	3,432	3,432	117,245	0	178,947	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,160	2,160	6,219	0	38,238	90.00
91.00	09100	EMERGENCY	23,463	23,463	3,518,036	0	5,249,333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	488,795	488,795	43,828,447	-16,809,184	86,756,417	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,330	2,330	0	0	18,508	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,332	5,332	4,089	0	51,253	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	201,494	0	594,251	194.01
194.02	07953	SENIOR CIRCLE	0	0	47,692	0	71,348	194.02
194.03	07952	MOB	28,833	28,833	0	0	251,595	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	110,971	4,472,681	5,899,619		16,809,184	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.211257	8.514689	0.133834		0.191572	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		661,575	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.007540	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/27/2016 2:16 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	387,120					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,863	968,980				8.00
9.00	00900	HOUSEKEEPING	0	0	374,257			9.00
10.00	01000	DIETARY	0	0	0	233,302		10.00
11.00	01100	CAFETERIA	25,328	5,692	25,328	95,272	55,303	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	2,173	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,144	0	6,144	0	1,543	14.00
15.00	01500	PHARMACY	3,836	0	3,836	0	1,962	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,322	0	4,322	0	1,448	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	82,558	213,754	82,558	83,794	13,953	30.00
31.00	03100	INTENSIVE CARE UNIT	14,534	65,517	14,534	6,698	3,433	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	5,668	1,744	40.00
43.00	04300	NURSERY	5,402	2,820	5,402	0	1,094	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,323	178,083	45,323	0	4,207	50.00
51.00	05100	RECOVERY ROOM	5,200	24,542	5,200	0	716	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,611	66,830	8,611	0	2,738	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	144	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,364	92,606	16,364	0	2,249	54.00
54.01	05401	ULTRASOUND	0	0	0	0	553	54.01
56.00	05600	RADIOISOTOPE	2,812	8,964	2,812	0	215	56.00
57.00	05700	CT SCAN	5,449	0	5,449	0	785	57.00
58.00	05800	MRI	1,040	0	1,040	0	221	58.00
60.00	06000	LABORATORY	16,180	0	16,180	0	3,898	60.00
65.00	06500	RESPIRATORY THERAPY	3,977	6,763	3,977	0	1,435	65.00
66.00	06600	PHYSICAL THERAPY	11,172	24,209	11,172	0	759	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	118	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	407	68.00
69.00	06900	ELECTROCARDIOLOGY	50,455	70,692	50,455	0	3,484	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	3,432	2,859	3,432	0	228	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,160	2,790	2,160	0	7	90.00
91.00	09100	EMERGENCY	23,463	175,076	23,463	4,166	5,497	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	350,625	941,197	337,762	195,598	55,011	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,330	0	2,330	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,332	6,893	5,332	34,594	14	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	182	194.01
194.02	07953	SENIOR CIRCLE	0	0	0	3,110	96	194.02
194.03	07952	MOB	28,833	20,890	28,833	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,473,037	1,554,860	3,870,604	2,961,347	2,232,672	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.304187	1.604636	10.342102	12.693192	40.371625	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	591,377	140,159	24,492	18,739	271,502	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.527632	0.144646	0.065442	0.080321	4.909354	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/27/2016 2:16 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	26,605,203					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,114,375				14.00
15.00	01500	PHARMACY	0	825,703	2,619,366			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,665	0	633,587,892		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,626,310	791,656	0	55,392,339	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,676,759	257,564	0	10,902,447	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,083,680	28,373	0	2,983,203	0	40.00
43.00	04300	NURSERY	897,992	70,895	0	10,342,009	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,301,696	404,036	0	127,378,112	0	50.00
51.00	05100	RECOVERY ROOM	687,910	18,895	0	7,912,612	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,545,937	195,326	0	8,871,226	0	52.00
53.00	05300	ANESTHESIOLOGY	56,947	184,143	0	14,965,711	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	180,881	0	22,627,664	0	54.00
54.01	05401	ULTRASOUND	0	14,034	0	9,660,606	0	54.01
56.00	05600	RADIOISOTOPE	0	5,917	0	5,261,132	0	56.00
57.00	05700	CT SCAN	0	75,185	0	38,339,785	0	57.00
58.00	05800	MRI	0	17,139	0	8,226,240	0	58.00
60.00	06000	LABORATORY	0	1,330,336	0	89,127,565	0	60.00
65.00	06500	RESPIRATORY THERAPY	943,155	121,721	0	9,292,430	0	65.00
66.00	06600	PHYSICAL THERAPY	0	15,949	0	4,090,021	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	142	0	638,282	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	778	0	1,806,744	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,143,317	565,074	0	38,620,655	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,599,775	0	9,576,635	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,623,803	0	40,051,774	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,619,366	40,294,064	0	73.00
74.00	07400	RENAL DIALYSIS	0	10,281	0	3,149,710	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	117,245	5,309	0	1,450,827	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,219	6,018	0	254,766	0	90.00
91.00	09100	EMERGENCY	3,518,036	757,102	0	72,371,333	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,605,203	15,112,700	2,619,366	633,587,892	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	487	0	0	0	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07953	SENIOR CIRCLE	0	1,188	0	0	0	194.02
194.03	07952	MOB	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,087,532	2,360,146	3,852,264	2,907,830	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.116050	0.156152	1.470686	0.004589	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	29,650	84,363	76,164	68,957	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001114	0.005582	0.029077	0.000109	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/27/2016 2:16 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,389,776		20,389,776	0	20,389,776	30.00
31.00	03100	INTENSIVE CARE UNIT	5,536,757		5,536,757	0	5,536,757	31.00
40.00	04000	SUBPROVIDER - IPF	2,000,565		2,000,565	0	2,000,565	40.00
43.00	04300	NURSERY	1,849,751		1,849,751	0	1,849,751	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,793,982		10,793,982	0	10,793,982	50.00
51.00	05100	RECOVERY ROOM	1,413,938		1,413,938	0	1,413,938	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,867,371		4,867,371	0	4,867,371	52.00
53.00	05300	ANESTHESIOLOGY	435,335		435,335	0	435,335	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,576,029		4,576,029	0	4,576,029	54.00
54.01	05401	ULTRASOUND	828,832		828,832	0	828,832	54.01
56.00	05600	RADIOISOTOPE	877,455		877,455	0	877,455	56.00
57.00	05700	CT SCAN	1,689,106		1,689,106	0	1,689,106	57.00
58.00	05800	MRI	524,039		524,039	0	524,039	58.00
60.00	06000	LABORATORY	7,545,505		7,545,505	0	7,545,505	60.00
65.00	06500	RESPIRATORY THERAPY	1,922,782	0	1,922,782	0	1,922,782	65.00
66.00	06600	PHYSICAL THERAPY	1,376,058	0	1,376,058	0	1,376,058	66.00
67.00	06700	OCCUPATIONAL THERAPY	141,411	0	141,411	0	141,411	67.00
68.00	06800	SPEECH PATHOLOGY	456,950	0	456,950	0	456,950	68.00
69.00	06900	ELECTROCARDIOLOGY	6,640,938		6,640,938	0	6,640,938	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,157,602		5,157,602	0	5,157,602	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,415,416		6,415,416	0	6,415,416	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,893,608		6,893,608	0	6,893,608	73.00
74.00	07400	RENAL DIALYSIS	594,224		594,224	0	594,224	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	349,860		349,860	0	349,860	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	117,190		117,190	0	117,190	90.00
91.00	09100	EMERGENCY	8,364,888		8,364,888	0	8,364,888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,865,945		1,865,945		1,865,945	92.00
200.00		Subtotal (see instructions)	103,625,313	0	103,625,313	0	103,625,313	200.00
201.00		Less Observation Beds	1,865,945		1,865,945		1,865,945	201.00
202.00		Total (see instructions)	101,759,368	0	101,759,368	0	101,759,368	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/27/2016 2:16 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,794,097		48,794,097			30.00
31.00	03100	INTENSIVE CARE UNIT	10,902,447		10,902,447			31.00
40.00	04000	SUBPROVIDER - IPF	2,983,203		2,983,203			40.00
43.00	04300	NURSERY	10,342,009		10,342,009			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	58,009,388	69,368,724	127,378,112	0.084740	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,853,289	3,059,323	7,912,612	0.178694	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,636,120	235,106	8,871,226	0.548669	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	6,843,401	8,122,310	14,965,711	0.029089	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,003,096	15,624,568	22,627,664	0.202232	0.000000	54.00
54.01	05401	ULTRASOUND	2,671,382	6,989,224	9,660,606	0.085795	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,639,656	2,621,476	5,261,132	0.166781	0.000000	56.00
57.00	05700	CT SCAN	15,663,557	22,676,228	38,339,785	0.044056	0.000000	57.00
58.00	05800	MRI	4,347,167	3,879,073	8,226,240	0.063703	0.000000	58.00
60.00	06000	LABORATORY	54,378,451	34,749,114	89,127,565	0.084660	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,816,759	475,671	9,292,430	0.206919	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,006,769	2,083,252	4,090,021	0.336443	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	404,584	233,698	638,282	0.221549	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,527,673	279,071	1,806,744	0.252914	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	21,432,946	17,187,709	38,620,655	0.171953	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,351,572	3,225,063	9,576,635	0.538561	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,591,416	15,460,358	40,051,774	0.160178	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,439,773	8,854,291	40,294,064	0.171082	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,971,991	177,719	3,149,710	0.188660	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	46,753	1,404,074	1,450,827	0.241145	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	37,607	217,159	254,766	0.459991	0.000000	90.00
91.00	09100	EMERGENCY	14,385,234	57,986,099	72,371,333	0.115583	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,690,162	4,908,080	6,598,242	0.282794	0.000000	92.00
200.00		Subtotal (see instructions)	353,770,502	279,817,390	633,587,892			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	353,770,502	279,817,390	633,587,892			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/27/2016 2:16 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.084740		50.00
51.00	05100	RECOVERY ROOM	0.178694		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.548669		52.00
53.00	05300	ANESTHESIOLOGY	0.029089		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202232		54.00
54.01	05401	ULTRASOUND	0.085795		54.01
56.00	05600	RADIOISOTOPE	0.166781		56.00
57.00	05700	CT SCAN	0.044056		57.00
58.00	05800	MRI	0.063703		58.00
60.00	06000	LABORATORY	0.084660		60.00
65.00	06500	RESPIRATORY THERAPY	0.206919		65.00
66.00	06600	PHYSICAL THERAPY	0.336443		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.221549		67.00
68.00	06800	SPEECH PATHOLOGY	0.252914		68.00
69.00	06900	ELECTROCARDIOLOGY	0.171953		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.538561		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.160178		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.171082		73.00
74.00	07400	RENAL DIALYSIS	0.188660		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.241145		76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.459991		90.00
91.00	09100	EMERGENCY	0.115583		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.282794		92.00
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: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/27/2016 2:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,389,776		20,389,776	0	20,389,776	30.00
31.00	03100	INTENSIVE CARE UNIT	5,536,757		5,536,757	0	5,536,757	31.00
40.00	04000	SUBPROVIDER - IPF	2,000,565		2,000,565	0	2,000,565	40.00
43.00	04300	NURSERY	1,849,751		1,849,751	0	1,849,751	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,793,982		10,793,982	0	10,793,982	50.00
51.00	05100	RECOVERY ROOM	1,413,938		1,413,938	0	1,413,938	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,867,371		4,867,371	0	4,867,371	52.00
53.00	05300	ANESTHESIOLOGY	435,335		435,335	0	435,335	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,576,029		4,576,029	0	4,576,029	54.00
54.01	05401	ULTRASOUND	828,832		828,832	0	828,832	54.01
56.00	05600	RADIOISOTOPE	877,455		877,455	0	877,455	56.00
57.00	05700	CT SCAN	1,689,106		1,689,106	0	1,689,106	57.00
58.00	05800	MRI	524,039		524,039	0	524,039	58.00
60.00	06000	LABORATORY	7,545,505		7,545,505	0	7,545,505	60.00
65.00	06500	RESPIRATORY THERAPY	1,922,782	0	1,922,782	0	1,922,782	65.00
66.00	06600	PHYSICAL THERAPY	1,376,058	0	1,376,058	0	1,376,058	66.00
67.00	06700	OCCUPATIONAL THERAPY	141,411	0	141,411	0	141,411	67.00
68.00	06800	SPEECH PATHOLOGY	456,950	0	456,950	0	456,950	68.00
69.00	06900	ELECTROCARDIOLOGY	6,640,938		6,640,938	0	6,640,938	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,157,602		5,157,602	0	5,157,602	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,415,416		6,415,416	0	6,415,416	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,893,608		6,893,608	0	6,893,608	73.00
74.00	07400	RENAL DIALYSIS	594,224		594,224	0	594,224	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	349,860		349,860	0	349,860	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	117,190		117,190	0	117,190	90.00
91.00	09100	EMERGENCY	8,364,888		8,364,888	0	8,364,888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,865,945		1,865,945		1,865,945	92.00
200.00		Subtotal (see instructions)	103,625,313	0	103,625,313	0	103,625,313	200.00
201.00		Less Observation Beds	1,865,945		1,865,945		1,865,945	201.00
202.00		Total (see instructions)	101,759,368	0	101,759,368	0	101,759,368	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/27/2016 2:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,794,097		48,794,097			30.00
31.00	03100	INTENSIVE CARE UNIT	10,902,447		10,902,447			31.00
40.00	04000	SUBPROVIDER - IPF	2,983,203		2,983,203			40.00
43.00	04300	NURSERY	10,342,009		10,342,009			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	58,009,388	69,368,724	127,378,112	0.084740	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,853,289	3,059,323	7,912,612	0.178694	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,636,120	235,106	8,871,226	0.548669	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	6,843,401	8,122,310	14,965,711	0.029089	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,003,096	15,624,568	22,627,664	0.202232	0.000000	54.00
54.01	05401	ULTRASOUND	2,671,382	6,989,224	9,660,606	0.085795	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,639,656	2,621,476	5,261,132	0.166781	0.000000	56.00
57.00	05700	CT SCAN	15,663,557	22,676,228	38,339,785	0.044056	0.000000	57.00
58.00	05800	MRI	4,347,167	3,879,073	8,226,240	0.063703	0.000000	58.00
60.00	06000	LABORATORY	54,378,451	34,749,114	89,127,565	0.084660	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,816,759	475,671	9,292,430	0.206919	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,006,769	2,083,252	4,090,021	0.336443	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	404,584	233,698	638,282	0.221549	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,527,673	279,071	1,806,744	0.252914	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	21,432,946	17,187,709	38,620,655	0.171953	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,351,572	3,225,063	9,576,635	0.538561	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,591,416	15,460,358	40,051,774	0.160178	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,439,773	8,854,291	40,294,064	0.171082	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,971,991	177,719	3,149,710	0.188660	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	46,753	1,404,074	1,450,827	0.241145	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	37,607	217,159	254,766	0.459991	0.000000	90.00
91.00	09100	EMERGENCY	14,385,234	57,986,099	72,371,333	0.115583	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,690,162	4,908,080	6,598,242	0.282794	0.000000	92.00
200.00		Subtotal (see instructions)	353,770,502	279,817,390	633,587,892			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	353,770,502	279,817,390	633,587,892			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/27/2016 2:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I | Date/Time Prepared: 5/27/2016 2:16 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	1,070,479	0	1,070,479	27,985	38.25	30.00
31.00	INTENSIVE CARE UNIT	210,145		210,145	3,120	67.35	31.00
40.00	SUBPROVIDER - IPF	21,555	0	21,555	1,663	12.96	40.00
43.00	NURSERY	73,399		73,399	3,736	19.65	43.00
200.00	Total (lines 30-199)	1,375,578		1,375,578	36,504		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	10,150	388,238				30.00
31.00	INTENSIVE CARE UNIT	1,396	94,021				31.00
40.00	SUBPROVIDER - IPF	1,181	15,306				40.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	12,727	497,565				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/27/2016 2:16 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	584,208	127,378,112	0.004586	19,982,363	91,639	50.00
51.00	05100	RECOVERY ROOM	69,243	7,912,612	0.008751	553,724	4,846	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	142,345	8,871,226	0.016046	36,266	582	52.00
53.00	05300	ANESTHESIOLOGY	5,489	14,965,711	0.000367	2,021,435	742	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	220,308	22,627,664	0.009736	3,435,398	33,447	54.00
54.01	05401	ULTRASOUND	8,655	9,660,606	0.000896	907,872	813	54.01
56.00	05600	RADIOISOTOPE	36,696	5,261,132	0.006975	1,165,198	8,127	56.00
57.00	05700	CT SCAN	72,960	38,339,785	0.001903	6,529,176	12,425	57.00
58.00	05800	MRI	15,619	8,226,240	0.001899	1,735,954	3,297	58.00
60.00	06000	LABORATORY	243,053	89,127,565	0.002727	21,023,703	57,332	60.00
65.00	06500	RESPIRATORY THERAPY	61,707	9,292,430	0.006641	3,825,349	25,404	65.00
66.00	06600	PHYSICAL THERAPY	129,084	4,090,021	0.031561	911,617	28,772	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,496	638,282	0.002344	192,719	452	67.00
68.00	06800	SPEECH PATHOLOGY	4,933	1,806,744	0.002730	403,461	1,101	68.00
69.00	06900	ELECTROCARDIOLOGY	585,424	38,620,655	0.015158	9,923,504	150,420	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	54,533	9,576,635	0.005694	2,321,983	13,221	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,034	40,051,774	0.001624	10,598,438	17,212	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	98,631	40,294,064	0.002448	12,056,965	29,515	73.00
74.00	07400	RENAL DIALYSIS	4,058	3,149,710	0.001288	1,696,152	2,185	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	38,616	1,450,827	0.026617	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	23,084	254,766	0.090609	17,663	1,600	90.00
91.00	09100	EMERGENCY	350,374	72,371,333	0.004841	6,065,439	29,363	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	97,964	6,598,242	0.014847	668,855	9,930	92.00
200.00		Total (lines 50-199)	2,913,514	560,566,136		106,073,234	522,425	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/27/2016 2:16 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	27,985	0.00	10,150	0		30.00
31.00	03100	INTENSIVE CARE UNIT	3,120	0.00	1,396	0		31.00
40.00	04000	SUBPROVIDER - IPF	1,663	0.00	1,181	0		40.00
43.00	04300	NURSERY	3,736	0.00	0	0		43.00
200.00		Total (lines 30-199)	36,504		12,727	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 2:16 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		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: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 2:16 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	127,378,112	0.000000	0.000000	19,982,363	50.00
51.00	05100	RECOVERY ROOM	0	7,912,612	0.000000	0.000000	553,724	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,871,226	0.000000	0.000000	36,266	52.00
53.00	05300	ANESTHESIOLOGY	0	14,965,711	0.000000	0.000000	2,021,435	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,627,664	0.000000	0.000000	3,435,398	54.00
54.01	05401	ULTRASOUND	0	9,660,606	0.000000	0.000000	907,872	54.01
56.00	05600	RADIOISOTOPE	0	5,261,132	0.000000	0.000000	1,165,198	56.00
57.00	05700	CT SCAN	0	38,339,785	0.000000	0.000000	6,529,176	57.00
58.00	05800	MRI	0	8,226,240	0.000000	0.000000	1,735,954	58.00
60.00	06000	LABORATORY	0	89,127,565	0.000000	0.000000	21,023,703	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,292,430	0.000000	0.000000	3,825,349	65.00
66.00	06600	PHYSICAL THERAPY	0	4,090,021	0.000000	0.000000	911,617	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	638,282	0.000000	0.000000	192,719	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,806,744	0.000000	0.000000	403,461	68.00
69.00	06900	ELECTROCARDIOLOGY	0	38,620,655	0.000000	0.000000	9,923,504	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,576,635	0.000000	0.000000	2,321,983	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,051,774	0.000000	0.000000	10,598,438	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	40,294,064	0.000000	0.000000	12,056,965	73.00
74.00	07400	RENAL DIALYSIS	0	3,149,710	0.000000	0.000000	1,696,152	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	1,450,827	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	254,766	0.000000	0.000000	17,663	90.00
91.00	09100	EMERGENCY	0	72,371,333	0.000000	0.000000	6,065,439	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,598,242	0.000000	0.000000	668,855	92.00
200.00		Total (lines 50-199)	0	560,566,136			106,073,234	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 2:16 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	25,551,371	0		50.00
51.00	05100	RECOVERY ROOM	0	868,907	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	2,373,677	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,164,598	0		54.00
54.01	05401	ULTRASOUND	0	453,381	0		54.01
56.00	05600	RADIOISOTOPE	0	673,769	0		56.00
57.00	05700	CT SCAN	0	5,177,983	0		57.00
58.00	05800	MRI	0	1,066,010	0		58.00
60.00	06000	LABORATORY	0	5,442,825	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	136,243	0		65.00
66.00	06600	PHYSICAL THERAPY	0	168	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	10,495	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,201,332	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	987,746	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,545,594	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,353,038	0		73.00
74.00	07400	RENAL DIALYSIS	0	111,144	0		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	0	415,580	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	67,524	0		90.00
91.00	09100	EMERGENCY	0	6,818,707	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,358,946	0		92.00
200.00		Total (lines 50-199)	0	72,779,038	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/27/2016 2:16 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	0.084740	25,551,371	0	0	2,165,223	50.00
51.00	05100	RECOVERY ROOM	0.178694	868,907	0	0	155,268	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.548669	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029089	2,373,677	0	0	69,048	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202232	4,164,598	0	0	842,215	54.00
54.01	05401	ULTRASOUND	0.085795	453,381	0	0	38,898	54.01
56.00	05600	RADIOISOTOPE	0.166781	673,769	0	0	112,372	56.00
57.00	05700	CT SCAN	0.044056	5,177,983	0	0	228,121	57.00
58.00	05800	MRI	0.063703	1,066,010	0	0	67,908	58.00
60.00	06000	LABORATORY	0.084660	5,442,825	3,204	0	460,790	60.00
65.00	06500	RESPIRATORY THERAPY	0.206919	136,243	0	0	28,191	65.00
66.00	06600	PHYSICAL THERAPY	0.336443	168	0	0	57	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.221549	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.252914	10,495	0	0	2,654	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171953	6,201,332	0	0	1,066,338	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.538561	987,746	0	0	531,961	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.160178	8,545,594	0	0	1,368,816	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.171082	2,353,038	0	37,237	402,562	73.00
74.00	07400	RENAL DIALYSIS	0.188660	111,144	0	0	20,968	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.241145	415,580	0	0	100,215	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.459991	67,524	0	0	31,060	90.00
91.00	09100	EMERGENCY	0.115583	6,818,707	0	0	788,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.282794	1,358,946	0	0	384,302	92.00
200.00		Subtotal (see instructions)		72,779,038	3,204	37,237	8,865,094	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		72,779,038	3,204	37,237	8,865,094	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/27/2016 2:16 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
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	271	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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	6,371		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
		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)	271	6,371		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	271	6,371		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140118 | Component CCN: 14S118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II | Date/Time Prepared: 5/27/2016 2:16 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	584,208	127,378,112	0.004586	9,965	46	50.00
51.00	05100	RECOVERY ROOM	69,243	7,912,612	0.008751	399	3	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	142,345	8,871,226	0.016046	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,489	14,965,711	0.000367	1,458	1	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	220,308	22,627,664	0.009736	11,815	115	54.00
54.01	05401	ULTRASOUND	8,655	9,660,606	0.000896	1,208	1	54.01
56.00	05600	RADIOISOTOPE	36,696	5,261,132	0.006975	0	0	56.00
57.00	05700	CT SCAN	72,960	38,339,785	0.001903	20,741	39	57.00
58.00	05800	MRI	15,619	8,226,240	0.001899	6,688	13	58.00
60.00	06000	LABORATORY	243,053	89,127,565	0.002727	154,021	420	60.00
65.00	06500	RESPIRATORY THERAPY	61,707	9,292,430	0.006641	38,229	254	65.00
66.00	06600	PHYSICAL THERAPY	129,084	4,090,021	0.031561	38,105	1,203	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,496	638,282	0.002344	7,807	18	67.00
68.00	06800	SPEECH PATHOLOGY	4,933	1,806,744	0.002730	3,607	10	68.00
69.00	06900	ELECTROCARDIOLOGY	585,424	38,620,655	0.015158	26,058	395	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	54,533	9,576,635	0.005694	3,287	19	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,034	40,051,774	0.001624	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	98,631	40,294,064	0.002448	302,189	740	73.00
74.00	07400	RENAL DIALYSIS	4,058	3,149,710	0.001288	25,973	33	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	38,616	1,450,827	0.026617	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	23,084	254,766	0.090609	0	0	90.00
91.00	09100	EMERGENCY	350,374	72,371,333	0.004841	20,422	99	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,598,242	0.000000	0	0	92.00
200.00		Total (lines 50-199)	2,815,550	560,566,136		671,972	3,409	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140118 | Component CCN: 14S118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 2:16 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		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: 140118 | Component CCN: 14S118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 2:16 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	127,378,112	0.000000	0.000000	9,965	50.00
51.00	05100	RECOVERY ROOM	0	7,912,612	0.000000	0.000000	399	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,871,226	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	14,965,711	0.000000	0.000000	1,458	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,627,664	0.000000	0.000000	11,815	54.00
54.01	05401	ULTRASOUND	0	9,660,606	0.000000	0.000000	1,208	54.01
56.00	05600	RADIOISOTOPE	0	5,261,132	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	38,339,785	0.000000	0.000000	20,741	57.00
58.00	05800	MRI	0	8,226,240	0.000000	0.000000	6,688	58.00
60.00	06000	LABORATORY	0	89,127,565	0.000000	0.000000	154,021	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,292,430	0.000000	0.000000	38,229	65.00
66.00	06600	PHYSICAL THERAPY	0	4,090,021	0.000000	0.000000	38,105	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	638,282	0.000000	0.000000	7,807	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,806,744	0.000000	0.000000	3,607	68.00
69.00	06900	ELECTROCARDIOLOGY	0	38,620,655	0.000000	0.000000	26,058	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,576,635	0.000000	0.000000	3,287	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,051,774	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	40,294,064	0.000000	0.000000	302,189	73.00
74.00	07400	RENAL DIALYSIS	0	3,149,710	0.000000	0.000000	25,973	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	1,450,827	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	254,766	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	72,371,333	0.000000	0.000000	20,422	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,598,242	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	560,566,136			671,972	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140118 | Component CCN: 14S118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/27/2016 2:16 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
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	495	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	2,122	0		57.00
58.00	05800	MRI	0	3,375	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,931	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
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	1,563	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	11,486	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140118 | Component CCN: 14S118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/27/2016 2:16 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	0.084740	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.178694	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.548669	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029089	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202232	495	0	0	100	54.00
54.01	05401	ULTRASOUND	0.085795	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.166781	0	0	0	0	56.00
57.00	05700	CT SCAN	0.044056	2,122	0	0	93	57.00
58.00	05800	MRI	0.063703	3,375	0	0	215	58.00
60.00	06000	LABORATORY	0.084660	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.206919	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.336443	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.221549	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.252914	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171953	3,931	0	0	676	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.538561	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.160178	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.171082	0	0	1,982	0	73.00
74.00	07400	RENAL DIALYSIS	0.188660	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.241145	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.459991	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.115583	1,563	0	0	181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.282794	0	0	0	0	92.00
200.00		Subtotal (see instructions)		11,486	0	1,982	1,265	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		11,486	0	1,982	1,265	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140118 | Component CCN: 14S118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/27/2016 2:16 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
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	339		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
		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	339		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	339		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/27/2016 2:16 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)	27,985	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	27,985	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)	25,424	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)	10,150	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	20,389,776	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	20,389,776	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	20,389,776	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)	728.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,395,290	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)	7,395,290	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/27/2016 2:16 pm

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	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	5,536,757	3,120	1,774.60	1,396	2,477,342	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)	14,194,609	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	24,067,241	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)	482,259	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	522,425	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,004,684	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	23,062,557	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)	2,561	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	728.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,865,945	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/27/2016 2:16 pm

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	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	1,070,479	20,389,776	0.052501	1,865,945	97,964	90.00
91.00	Nursing School cost	0	20,389,776	0.000000	1,865,945	0	91.00
92.00	Allied health cost	0	20,389,776	0.000000	1,865,945	0	92.00
93.00	All other Medical Education	0	20,389,776	0.000000	1,865,945	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140118 Component CCN: 14S118	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/27/2016 2:16 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)	1,663	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,663	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)	1,663	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)	1,181	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)	2,000,565	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)	2,000,565	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)	2,000,565	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)	1,202.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,420,731	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)	1,420,731	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140118 | Component CCN: 14S118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/27/2016 2:16 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)	106,411	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,527,142	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)	15,306	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,409	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	18,715	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,508,427	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: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1

Component CCN: 14S118 | Date/Time Prepared: 5/27/2016 2:16 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	21,555	2,000,565	0.010774	0	0	90.00
91.00	Nursing School cost	0	2,000,565	0.000000	0	0	91.00
92.00	Allied health cost	0	2,000,565	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,000,565	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/27/2016 2:16 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		20,090,659		30.00
31.00	03100	INTENSIVE CARE UNIT		4,869,292		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	0.084740	19,982,363	1,693,305	50.00
51.00	05100	RECOVERY ROOM	0.178694	553,724	98,947	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.548669	36,266	19,898	52.00
53.00	05300	ANESTHESIOLOGY	0.029089	2,021,435	58,802	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202232	3,435,398	694,747	54.00
54.01	05401	ULTRASOUND	0.085795	907,872	77,891	54.01
56.00	05600	RADIOISOTOPE	0.166781	1,165,198	194,333	56.00
57.00	05700	CT SCAN	0.044056	6,529,176	287,649	57.00
58.00	05800	MRI	0.063703	1,735,954	110,585	58.00
60.00	06000	LABORATORY	0.084660	21,023,703	1,779,867	60.00
65.00	06500	RESPIRATORY THERAPY	0.206919	3,825,349	791,537	65.00
66.00	06600	PHYSICAL THERAPY	0.336443	911,617	306,707	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.221549	192,719	42,697	67.00
68.00	06800	SPEECH PATHOLOGY	0.252914	403,461	102,041	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171953	9,923,504	1,706,376	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.538561	2,321,983	1,250,529	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.160178	10,598,438	1,697,637	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.171082	12,056,965	2,062,730	73.00
74.00	07400	RENAL DIALYSIS	0.188660	1,696,152	319,996	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.241145	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.459991	17,663	8,125	90.00
91.00	09100	EMERGENCY	0.115583	6,065,439	701,062	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.282794	668,855	189,148	92.00
200.00		Total (sum of lines 50-94 and 96-98)		106,073,234	14,194,609	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)		106,073,234		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140118 | Component CCN: 14S118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/27/2016 2:16 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		2,114,379		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.084740	9,965	844	50.00
51.00	05100	RECOVERY ROOM	0.178694	399	71	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.548669	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029089	1,458	42	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202232	11,815	2,389	54.00
54.01	05401	ULTRASOUND	0.085795	1,208	104	54.01
56.00	05600	RADIOISOTOPE	0.166781	0	0	56.00
57.00	05700	CT SCAN	0.044056	20,741	914	57.00
58.00	05800	MRI	0.063703	6,688	426	58.00
60.00	06000	LABORATORY	0.084660	154,021	13,039	60.00
65.00	06500	RESPIRATORY THERAPY	0.206919	38,229	7,910	65.00
66.00	06600	PHYSICAL THERAPY	0.336443	38,105	12,820	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.221549	7,807	1,730	67.00
68.00	06800	SPEECH PATHOLOGY	0.252914	3,607	912	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171953	26,058	4,481	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.538561	3,287	1,770	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.160178	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.171082	302,189	51,699	73.00
74.00	07400	RENAL DIALYSIS	0.188660	25,973	4,900	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.241145	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.459991	0	0	90.00
91.00	09100	EMERGENCY	0.115583	20,422	2,360	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.282794	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		671,972	106,411	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)		671,972		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 5/27/2016 2:16 pm

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		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)		16,079,042		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		5,232,550		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)		332,222		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		6,346,885		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		292.98		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		6.48		30.00
31.00	Percentage of Medicaid patient days (see instructions)		33.31		31.00
32.00	Sum of lines 30 and 31		39.79		32.00
33.00	Allowable disproportionate share percentage (see instructions)		22.04		33.00
34.00	Disproportionate share adjustment (see instructions)		1,174,269		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A | Date/Time Prepared: 5/27/2016 2:16 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)		0.000403677	0.000395421	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		3,087,178	2,533,121	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		2,309,039	636,740	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,945,779		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)		2,567		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		336		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		336		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		13.09		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		2,110		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.897109		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		417.60		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		125,876		46.00
47.00	Subtotal (see instructions)		25,889,738		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)		25,889,738		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,854,166		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		20,885		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)		27,764,789		59.00
60.00	Primary payer payments		4,858		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		27,759,931		61.00
62.00	Deductibles billed to program beneficiaries		2,276,980		62.00
63.00	Coinsurance billed to program beneficiaries		36,855		63.00
64.00	Allowable bad debts (see instructions)		753,370		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		489,691		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		558,739		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		25,935,787		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)		52,508		70.93
70.94	HRR adjustment amount (see instructions)		-229,383		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 5/27/2016 2:16 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)		25,758,912		71.00
71.01	Sequestration adjustment (see instructions)		515,178		71.01
72.00	Interim payments		24,083,612		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)		1,160,122		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,301,455		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: 140118	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/27/2016 2:16 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,642	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	8,865,094	2.00
3.00	PPS payments	9,149,060	3.00
4.00	Outlier payment (see instructions)	106,178	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)	6,642	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	40,441	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)	40,441	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)	40,441	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	33,799	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)	6,642	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)	9,255,238	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,658,753	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)	7,603,127	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)	7,603,127	30.00
31.00	Primary payer payments	323	31.00
32.00	Subtotal (line 30 minus line 31)	7,602,804	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)	469,859	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	305,408	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	407,014	36.00
37.00	Subtotal (see instructions)	7,908,212	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)	7,908,212	40.00
40.01	Sequestration adjustment (see instructions)	158,164	40.01
41.00	Interim payments	7,717,887	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	32,161	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: 140118 Component CCN: 14S118	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/27/2016 2:16 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	339	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,265	2.00
3.00	PPS payments	1,741	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)	339	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,982	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)	1,982	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)	1,982	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,643	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)	339	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)	1,741	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)	251	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)	1,829	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)	1,829	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,829	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)	1,829	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)	1,829	40.00
40.01	Sequestration adjustment (see instructions)	37	40.01
41.00	Interim payments	1,845	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-53	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: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2016 2:16 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		24,166,809		7,768,213	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	08/11/2015	83,197	08/11/2015	50,326	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)		-83,197		-50,326	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)		24,083,612		7,717,887	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		1,160,122		32,161	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		25,243,734		7,750,048	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: 140118 | Component CCN: 14S118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2016 2:16 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		1,041,140		1,845	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,041,140		1,845	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		469		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		53	6.02
7.00	Total Medicare program liability (see instructions)		1,041,609		1,792	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	Provider CCN: 140118 Component CCN: 14S118	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part II Date/Time Prepared: 5/27/2016 2:16 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)	1,114,384	1.00
2.00	Net IPF PPS Outlier Payments	24,106	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)	4.556164	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)	1,138,490	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)	1,138,490	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,138,490	18.00
19.00	Deductibles	69,168	19.00
20.00	Subtotal (line 18 minus line 19)	1,069,322	20.00
21.00	Coinsurance	6,930	21.00
22.00	Subtotal (line 20 minus line 21)	1,062,392	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	729	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	474	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	288	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,062,866	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)	1,062,866	31.00
31.01	Sequestration adjustment (see instructions)	21,257	31.01
32.00	Interim payments	1,041,140	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)	469	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	24,106	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/27/2016 2:16 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	-805,227	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	34,624,215	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,604,906	0	0	0	6.00
7.00	Inventory	4,785,216	0	0	0	7.00
8.00	Prepaid expenses	815,448	0	0	0	8.00
9.00	Other current assets	1,902,846	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)	35,717,592	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,610,000	0	0	0	12.00
13.00	Land improvements	2,404,000	0	0	0	13.00
14.00	Accumulated depreciation	-1,784,033	0	0	0	14.00
15.00	Buildings	23,379,613	0	0	0	15.00
16.00	Accumulated depreciation	-3,994,746	0	0	0	16.00
17.00	Leasehold improvements	5,170,178	0	0	0	17.00
18.00	Accumulated depreciation	-836,560	0	0	0	18.00
19.00	Fixed equipment	1,840,985	0	0	0	19.00
20.00	Accumulated depreciation	-775,189	0	0	0	20.00
21.00	Automobiles and trucks	21,120	0	0	0	21.00
22.00	Accumulated depreciation	-20,240	0	0	0	22.00
23.00	Major movable equipment	13,417,170	0	0	0	23.00
24.00	Accumulated depreciation	-8,877,315	0	0	0	24.00
25.00	Minor equipment depreciable	9,238,901	0	0	0	25.00
26.00	Accumulated depreciation	-3,765,687	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)	38,028,197	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	9,088,649	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,088,649	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	82,834,438	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	10,245,714	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,043,739	0	0	0	38.00
39.00	Payroll taxes payable	411,231	0	0	0	39.00
40.00	Notes and loans payable (short term)	-8	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	94,657,892	0	0	0	43.00
44.00	Other current liabilities	1,388,619	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	110,747,187	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	28,088	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	28,088	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	110,775,275	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-27,940,837				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)	-27,940,837	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	82,834,438	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/27/2016 2:16 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		-18,133,719		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-9,807,039				2.00
3.00	Total (sum of line 1 and line 2)		-27,940,758		0		3.00
4.00		0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-27,940,758		0		11.00
12.00	OTHER - ROUNDING	79		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		79		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-27,940,837		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			0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	OTHER - ROUNDING		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/27/2016 2:16 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	59,136,106		59,136,106	1.00
2.00	SUBPROVIDER - IPF	2,983,203		2,983,203	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)	62,119,309		62,119,309	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	10,902,447		10,902,447	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)	10,902,447		10,902,447	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	73,021,756		73,021,756	17.00
18.00	Ancillary services	264,635,743	216,706,052	481,341,795	18.00
19.00	Outpatient services	16,113,003	63,111,338	79,224,341	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	353,770,502	279,817,390	633,587,892	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		148,117,125		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		148,117,125		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140118 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-3 | Date/Time Prepared: 5/27/2016 2:16 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	633,587,892	1.00
2.00	Less contractual allowances and discounts on patients' accounts	496,063,198	2.00
3.00	Net patient revenues (line 1 minus line 2)	137,524,694	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	148,117,125	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-10,592,431	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	785,392	24.00
25.00	Total other income (sum of lines 6-24)	785,392	25.00
26.00	Total (line 5 plus line 25)	-9,807,039	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-9,807,039	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140118	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/27/2016 2:16 pm
	Title XVIII	Hospital	PPS

			1.00
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,705,237	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	5,860	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)	79.55	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	6.48	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	33.31	8.00
9.00	Sum of lines 7 and 8	39.79	9.00
10.00	Allowable disproportionate share percentage (see instructions)	8.39	10.00
11.00	Disproportionate share adjustment (see instructions)	143,069	11.00
12.00	Total prospective capital payments (see instructions)	1,854,166	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