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: 150075	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/29/2016 1:38 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/29/2016 Time: 1:38 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 BLUFFTON REGIONAL MEDICAL CENTER (150075) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	91,487	32,292	339,111	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	91,487	32,292	339,111	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: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/29/2016 1:35 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 S. MAIN STREET	PO Box:			1.00
2.00	City: BLUFFTON	State: IN	Zip Code: 46714-	County: WELLS	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	BLUFFTON REGIONAL MEDICAL CENTER	150075	23060	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	BLUFFTON SKILLED NURSING	155373	23060		03/13/1991	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2014	09/30/2015	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	505	255	0	0	432	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/29/2016 1:35 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)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, 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

		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: 150075	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/29/2016 1:35 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.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	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

		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				N	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.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	16,795	32,226	0	118.01

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

		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: CHS / COMMUNITY HEALTH SYSTEMS, INC.	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.	N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.25	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2014	12/29/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150075	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/29/2016 1:35 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: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 2/29/2016 1:35 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	12/22/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150075	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part II Date/Time Prepared: 2/29/2016 1:35 pm

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2014	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LISA	PARRISH	41.00
42.00	Enter the employer/company name of the cost report preparer.	CHS/COMMUNITY HEALTH SYSTEMS, INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 465-7554	LISA_PARRISH@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150075	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part II Date/Time Prepared: 2/29/2016 1:35 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)	12/22/2015	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SR. MANAGER, REVENUE MANAGEMENT		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: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/29/2016 1:35 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	55	20,075	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)		55	20,075	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	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)		62	22,630	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	13	4,745		0	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)		75				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: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/29/2016 1:35 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)	2,304	580	5,100			1.00
2.00	HMO and other (see instructions)	1,159	432				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)	2,304	580	5,100			7.00
8.00	INTENSIVE CARE UNIT	391	10	752			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		170	517			13.00
14.00	Total (see instructions)	2,695	760	6,369	0.00	220.85	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	1,604	0	2,779	0.00	12.04	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	232.89	27.00
28.00	Observation Bed Days		0	1,398			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/29/2016 1:35 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	711	201	1,638	1.00
2.00	HMO and other (see instructions)			300	0		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	711	201	1,638	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					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: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 2/29/2016 1:35 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	11,860,436	0	11,860,436	484,417.00	24.48	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	591,333	0	591,333	25,040.00	23.62	9.00
10.00	Excluded area salaries (see instructions)		5,868	52,781	58,649	2,164.00	27.10	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		14,890	0	14,890	52.00	286.35	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		144,157	0	144,157	1,118.88	128.84	13.00
14.00	Home office salaries & wage-related costs		633,470	0	633,470	10,383.00	61.01	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)		2,746,753	0	2,746,753			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		161,788	0	161,788			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	94,800	68,723	163,523	4,744.00	34.47	26.00
27.00	Administrative & General	5.00	1,464,113	-196,396	1,267,717	60,239.00	21.04	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	303,702	0	303,702	13,667.00	22.22	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	245,204	0	245,204	19,742.00	12.42	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	438,628	-345,414	93,214	6,981.66	13.35	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	345,414	345,414	25,871.34	13.35	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	905,890	74,892	980,782	24,920.00	39.36	38.00
39.00	Central Services and Supply	14.00	65,652	0	65,652	4,084.00	16.08	39.00
40.00	Pharmacy	15.00	512,178	0	512,178	13,038.00	39.28	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150075

Period: From 10/01/2014 To 09/30/2015

Worksheet S-3 Part II
Date/Time Prepared: 2/29/2016 1:35 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	406,056	0	406,056	20,440.00	19.87	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: 150075

Period: From 10/01/2014 To 09/30/2015

Worksheet S-3 Part III
Date/Time Prepared: 2/29/2016 1:35 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)		11,860,436	0	11,860,436	484,417.00	24.48	1.00
2.00	Excluded area salaries (see instructions)		597,201	52,781	649,982	27,204.00	23.89	2.00
3.00	Subtotal salaries (line 1 minus line 2)		11,263,235	-52,781	11,210,454	457,213.00	24.52	3.00
4.00	Subtotal other wages & related costs (see inst.)		792,517	0	792,517	11,553.88	68.59	4.00
5.00	Subtotal wage-related costs (see inst.)		2,746,753	0	2,746,753	0.00	24.50	5.00
6.00	Total (sum of lines 3 thru 5)		14,802,505	-52,781	14,749,724	468,766.88	31.46	6.00
7.00	Total overhead cost (see instructions)		4,436,223	-52,781	4,383,442	193,727.00	22.63	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150075	Period: From 10/01/2014 To 09/30/2015	Worksheet S-3 Part IV Date/Time Prepared: 2/29/2016 1:35 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	259,040	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)	1,417,684	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	18,274	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	11,401	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	7,817	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	216,253	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	734,897	17.00
18.00	Medicare Taxes - Employers Portion Only	171,871	18.00
19.00	Unemployment Insurance	53,099	19.00
20.00	State or Federal Unemployment Taxes	18,128	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)	2,908,464	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS	124,870	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part V Date/Time Prepared: 2/29/2016 1:35 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			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	0	0	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			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-7 Date/Time Prepared: 2/29/2016 1:35 pm

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

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	0	0	0	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	14	0	14	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	19	0	19	14.00
15.00	RVC	164	0	164	15.00
16.00	RVB	173	0	173	16.00
17.00	RVA	28	0	28	17.00
18.00	RHC	179	0	179	18.00
19.00	RHB	455	0	455	19.00
20.00	RHA	148	0	148	20.00
21.00	RMC	41	0	41	21.00
22.00	RMB	109	0	109	22.00
23.00	RMA	46	0	46	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	13	0	13	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	3	0	3	32.00
33.00	HC2	4	0	4	33.00
34.00	HC1	4	0	4	34.00
35.00	HB2	2	0	2	35.00
36.00	HB1	24	0	24	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	7	0	7	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	4	0	4	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	6	0	6	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	7	0	7	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	7	0	7	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	66	0	66	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	25	0	25	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	40	0	40	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-7 | Date/Time Prepared: 2/29/2016 1:35 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	10	0	10	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	6	0	6	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,604	0	1,604	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	23060	23060	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2,612,744			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-10 | Date/Time Prepared: 2/29/2016 1:35 pm

Line	Description			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)			0.176541	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			2,885,310	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			968,566	5.00
6.00	Medicaid charges			18,849,592	6.00
7.00	Medicaid cost (line 1 times line 6)			3,327,726	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP			0	9.00
10.00	Stand-alone SCHIP charges			0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
	Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			85,229	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			928,177	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			163,861	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)			78,632	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)			78,632	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	282,762	0	282,762	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	49,919	0	49,919	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	49,919	0	49,919	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			5,452,713	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			40,990	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			5,411,723	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			955,391	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,005,310	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,083,942	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/29/2016 1:35 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		2,009,401	2,009,401	261,960	2,271,361	1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT		0	0	0	0	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,741,968	2,741,968	374,888	3,116,856	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	94,800	49,647	144,447	2,139,770	2,284,217	4.00
5.01	01160	COMMUNICATIONS	0	0	0	404,662	404,662	5.01
5.02	00540	ADMITTING	0	0	0	362,999	362,999	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	1,017,438	1,017,438	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	1,464,113	13,329,305	14,793,418	-4,490,977	10,302,441	5.04
7.00	00700	OPERATION OF PLANT	303,702	1,569,250	1,872,952	-2,512	1,870,440	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	131,482	131,482	0	131,482	8.00
9.00	00900	HOUSEKEEPING	245,204	143,532	388,736	-1,016	387,720	9.00
10.00	01000	DIETARY	438,628	298,122	736,750	-581,131	155,619	10.00
11.00	01100	CAFETERIA	0	0	0	576,660	576,660	11.00
13.00	01300	NURSING ADMINISTRATION	905,890	166,786	1,072,676	56,923	1,129,599	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	65,652	1,230,633	1,296,285	-819,367	476,918	14.00
15.00	01500	PHARMACY	512,178	1,166,974	1,679,152	-974,917	704,235	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	406,056	119,832	525,888	-8,347	517,541	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,795,368	583,959	2,379,327	-482,823	1,896,504	30.00
31.00	03100	INTENSIVE CARE UNIT	654,976	88,793	743,769	-1,381	742,388	31.00
43.00	04300	NURSERY	0	0	0	267,260	267,260	43.00
44.00	04400	SKILLED NURSING FACILITY	591,333	107,414	698,747	-3,011	695,736	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	510,945	785,435	1,296,380	551,812	1,848,192	50.00
51.00	05100	RECOVERY ROOM	355,164	70,988	426,152	-426,152	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	177,467	177,467	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	501,773	174,668	676,441	403,233	1,079,674	54.00
54.01	03630	ULTRA SOUND	104,558	19,070	123,628	-123,628	0	54.01
56.00	05600	RADIOISOTOPE	65,090	73,071	138,161	0	138,161	56.00
57.00	05700	CT SCAN	154,503	42,186	196,689	-196,689	0	57.00
58.00	05800	MRI	112,488	95,442	207,930	-207,930	0	58.00
60.00	06000	LABORATORY	634,513	913,156	1,547,669	-82,115	1,465,554	60.00
65.00	06500	RESPIRATORY THERAPY	367,258	49,587	416,845	-1,078	415,767	65.00
66.00	06600	PHYSICAL THERAPY	394,473	73,992	468,465	256,077	724,542	66.00
67.00	06700	OCCUPATIONAL THERAPY	163,417	14,589	178,006	-178,006	0	67.00
68.00	06800	SPEECH PATHOLOGY	69,704	9,706	79,410	-79,410	0	68.00
69.00	06900	ELECTROCARDIOLOGY	160,837	26,822	187,659	0	187,659	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	50,365	50,365	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	616,939	616,939	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	926,774	926,774	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	20,477	17,113	37,590	-501	37,089	76.01
76.03	03953	WOUND CARE	84,805	25,162	109,967	0	109,967	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	49,374	15,524	64,898	0	64,898	90.00
91.00	09100	EMERGENCY	627,289	149,251	776,540	247,057	1,023,597	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	249,553	249,553	-249,553	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,854,568	26,542,413	38,396,981	-218,260	38,178,721	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,878	33,697	35,575	0	35,575	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	217,943	217,943	194.01
194.02	07952	SENIOR CIRCLE	3,990	2,120	6,110	-417	5,693	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	734	734	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	11,860,436	26,578,230	38,438,666	0	38,438,666	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A Date/Time Prepared: 2/29/2016 1:35 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	155,397	2,426,758	1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	127,117	127,117	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,122,990	1,993,866	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-514	2,283,703	4.00
5.01	01160	COMMUNICATIONS	-18,858	385,804	5.01
5.02	00540	ADMITTING	0	362,999	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	1,017,438	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	-5,761,847	4,540,594	5.04
7.00	00700	OPERATION OF PLANT	0	1,870,440	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	131,482	8.00
9.00	00900	HOUSEKEEPING	0	387,720	9.00
10.00	01000	DIETARY	0	155,619	10.00
11.00	01100	CAFETERIA	-35,807	540,853	11.00
13.00	01300	NURSING ADMINISTRATION	-26,943	1,102,656	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	476,918	14.00
15.00	01500	PHARMACY	0	704,235	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-837	516,704	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-109,690	1,786,814	30.00
31.00	03100	INTENSIVE CARE UNIT	0	742,388	31.00
43.00	04300	NURSERY	0	267,260	43.00
44.00	04400	SKILLED NURSING FACILITY	0	695,736	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-649,296	1,198,896	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	177,467	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,079,674	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	138,161	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	1,465,554	60.00
65.00	06500	RESPIRATORY THERAPY	0	415,767	65.00
66.00	06600	PHYSICAL THERAPY	0	724,542	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	187,659	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	50,365	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	616,939	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-28	926,746	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.01	03951	SLEEP LAB	0	37,089	76.01
76.03	03953	WOUND CARE	0	109,967	76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	64,898	90.00
91.00	09100	EMERGENCY	-216,153	807,444	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,660,449	30,518,272	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	35,575	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	194.00
194.01	07955	MARKETING	0	217,943	194.01
194.02	07952	SENIOR CIRCLE	0	5,693	194.02
194.03	07953	BUSINESS HEALTH	0	734	194.03
194.04	07954	VACANT SPACE	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	-7,660,449	30,778,217	200.00

RECLASSIFICATIONS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/29/2016 1:35 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,055,339	1.00
	0		0	2,055,339	
	B - RECLASS OXYGEN				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	10,225	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	10,225	
	C - RECLASS RENTAL AND LEASE EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	366,363	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	0		0	366,363	
	D - RECLASS OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	65,321	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	196,639	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,525	3.00
4.00		0.00	0	0	4.00
	0		0	270,485	
	E - RECLASS MARKETING DEPT				
1.00	MARKETING	194.01	52,781	165,162	1.00
2.00		0.00	0	0	2.00
	0		52,781	165,162	
	F - RECLASS CNO COSTS				
1.00	NURSING ADMINISTRATION	13.00	143,615	0	1.00
2.00		0.00	0	0	2.00
	0		143,615	0	
	G - RECLASS MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	40,140	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	616,939	2.00
3.00	OPERATING ROOM	50.00	0	128,076	3.00
	0		0	785,155	
	H - RECLASS COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	926,774	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	926,774	
	I - RECLASS LABOR AND DELIVERY COSTS				
1.00	NURSERY	43.00	206,335	60,925	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	137,011	40,456	2.00
3.00		0.00	0	0	3.00
	0		343,346	101,381	
	J - RECLASS MISC DEPARTMENTS				
1.00	OPERATING ROOM	50.00	355,164	69,973	1.00
2.00	PHYSICAL THERAPY	66.00	233,121	24,295	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	68,723	17,587	3.00
4.00	BUSINESS HEALTH	194.03	0	734	4.00
5.00	EMERGENCY	91.00	0	249,553	5.00
6.00		0.00	0	0	6.00
	0		657,008	362,142	

RECLASSIFICATIONS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/29/2016 1:35 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	K - RECLASS OTHER RADIOLOGY COSTS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	371,549	110,198	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		371,549	110,198	
	L - RECLASS A PORTION OF DIETARY TO CAFE				
1.00	CAFETERIA	11.00	345,414	231,246	1.00
2.00		0.00	0	0	2.00
	0		345,414	231,246	
	M - RECLASS ADMIN AND GENERAL COSTS				
1.00	COMMUNICATIONS	5.01	34,832	369,830	1.00
2.00	ADMITTING	5.02	310,641	52,358	2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	149,751	867,687	3.00
4.00		0.00	0	0	4.00
	0		495,224	1,289,875	
500.00	Grand Total: Increases		2,408,937	6,674,345	500.00

RECLASSIFICATIONS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/29/2016 1:35 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - RECLASS EMPLOYEE BENEFITS					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	2,055,339	0	1.00
	0		0	2,055,339		
	B - RECLASS OXYGEN					
1.00		0.00	0	0	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	9,405	0	2.00
3.00	OPERATION OF PLANT	7.00	0	820	0	3.00
	0		0	10,225		
	C - RECLASS RENTAL AND LEASE EXPENSE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,879	10	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	18,496	0	2.00
3.00	OPERATION OF PLANT	7.00	0	1,692	0	3.00
4.00	HOUSEKEEPING	9.00	0	1,016	0	4.00
5.00	DIETARY	10.00	0	4,471	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	382	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	24,807	0	7.00
8.00	PHARMACY	15.00	0	48,294	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	8,347	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	38,096	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	1,381	0	11.00
12.00	SKILLED NURSING FACILITY	44.00	0	2,860	0	12.00
13.00	OPERATING ROOM	50.00	0	1,401	0	13.00
14.00	RECOVERY ROOM	51.00	0	1,015	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	78,514	0	15.00
16.00	MRI	58.00	0	46,500	0	16.00
17.00	LABORATORY	60.00	0	81,381	0	17.00
18.00	RESPIRATORY THERAPY	65.00	0	1,078	0	18.00
19.00	PHYSICAL THERAPY	66.00	0	1,339	0	19.00
20.00	SLEEP LAB	76.01	0	501	0	20.00
21.00	EMERGENCY	91.00	0	2,496	0	21.00
22.00	SENIOR CIRCLE	194.02	0	417	0	22.00
	0		0	366,363		
	D - RECLASS OTHER CAPITAL COSTS					
1.00		0.00	0	0	12	1.00
2.00		0.00	0	0	13	2.00
3.00		0.00	0	0	12	3.00
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	270,485	0	4.00
	0		0	270,485		
	E - RECLASS MARKETING DEPT					
1.00		0.00	0	0	0	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	52,781	165,162	0	2.00
	0		52,781	165,162		
	F - RECLASS CNO COSTS					
1.00		0.00	0	0	0	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	143,615	0	0	2.00
	0		143,615	0		
	G - RECLASS MEDICAL SUPPLIES					
1.00		0.00	0	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	785,155	0	3.00
	0		0	785,155		
	H - RECLASS COST OF DRUGS/IV SOLUTIONS					
1.00		0.00	0	0	0	1.00
2.00	PHARMACY	15.00	0	926,623	0	2.00
3.00	SKILLED NURSING FACILITY	44.00	0	151	0	3.00
	0		0	926,774		
	I - RECLASS LABOR AND DELIVERY COSTS					
1.00		0.00	0	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	343,346	101,381	0	3.00
	0		343,346	101,381		
	J - RECLASS MISC DEPARTMENTS					
1.00	RECOVERY ROOM	51.00	355,164	69,973	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	163,417	14,589	0	2.00
3.00	SPEECH PATHOLOGY	68.00	69,704	9,706	0	3.00
4.00	NURSING ADMINISTRATION	13.00	68,723	17,587	0	4.00
5.00	LABORATORY	60.00	0	734	0	5.00
6.00	AMBULANCE SERVICES	95.00	0	249,553	0	6.00
	0		657,008	362,142		

RECLASSIFICATIONS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 Date/Time Prepared: 2/29/2016 1:35 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	K - RECLASS OTHER RADIOLOGY COSTS					
1.00		0.00	0	0	0	1.00
2.00	ULTRA SOUND	54.01	104,558	19,070	0	2.00
3.00	CT SCAN	57.00	154,503	42,186	0	3.00
4.00	MRI	58.00	112,488	48,942	0	4.00
	0		371,549	110,198		
	L - RECLASS A PORTION OF DIETARY TO CAFE					
1.00		0.00	0	0	0	1.00
2.00	DIETARY	10.00	345,414	231,246	0	2.00
	0		345,414	231,246		
	M - RECLASS ADMIN AND GENERAL COSTS					
1.00		0.00	0	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	495,224	1,289,875	0	4.00
	0		495,224	1,289,875		
500.00	Grand Total: Decreases		2,408,937	6,674,345		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part I Date/Time Prepared: 2/29/2016 1:35 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,844,900	0	0	0	0	1.00
2.00	Land Improvements	748,002	0	0	0	0	2.00
3.00	Buildings and Fixtures	21,415,381	3,750	0	3,750	0	3.00
4.00	Building Improvements	4,729,181	188,501	0	188,501	0	4.00
5.00	Fixed Equipment	4,171,036	51,897	0	51,897	0	5.00
6.00	Movable Equipment	13,901,006	1,283,717	0	1,283,717	204,852	6.00
7.00	HIT designated Assets	4,287,266	4,177	0	4,177	85,406	7.00
8.00	Subtotal (sum of lines 1-7)	53,096,772	1,532,042	0	1,532,042	290,258	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	53,096,772	1,532,042	0	1,532,042	290,258	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,844,900	0	1.00
2.00	Land Improvements	748,002	0	2.00
3.00	Buildings and Fixtures	21,419,131	0	3.00
4.00	Building Improvements	4,917,682	0	4.00
5.00	Fixed Equipment	4,222,933	0	5.00
6.00	Movable Equipment	14,979,871	0	6.00
7.00	HIT designated Assets	4,206,037	0	7.00
8.00	Subtotal (sum of lines 1-7)	54,338,556	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	54,338,556	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150075

Period: From 10/01/2014 To 09/30/2015

Worksheet A-7 Part II

Date/Time Prepared: 2/29/2016 1:35 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	2,009,401	0	0	0	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	2,741,968	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,751,369	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2,009,401	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,741,968	2.00
3.00	Total (sum of lines 1-2)	0	4,751,369	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part III | Date/Time Prepared: 2/29/2016 1:35 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	30,929,715	0	30,929,715	0.569204	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	23,408,841	0	23,408,841	0.430796	0	2.00
3.00	Total (sum of lines 1-2)	54,338,556	0	54,338,556	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,882,142	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	127,117	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,618,989	366,363	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,628,248	366,363	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	268,751	65,321	196,639	13,905	2,426,758	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0	127,117	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,525	0	-11	1,993,866	2.00
3.00	Total (sum of lines 1-2)	268,751	73,846	196,639	13,894	4,547,741	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/29/2016 1:35 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
1.01	Investment income - WELLS CRC COSTS-BLDG & FIXT (chapter 2)		0	WELLS CRC COSTS-BLDG & FIXT	1.01	0	1.01
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	-18,858	COMMUNICATIONS	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-220	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-345,959			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	-409,193			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-35,807	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-28	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-837	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-127,259	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - WELLS CRC COSTS-BLDG & FIXT	A	127,117	WELLS CRC COSTS-BLDG & FIXT	1.01	9	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,122,979	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/29/2016 1:35 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	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INSERVICE EDUCATION	B	-9,890	NURSING ADMINISTRATION	13.00	0	33.00
33.01	FITNESS REVENUE	B	-312,339	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.01
33.02	OTHER MISC REVENUE	B	-34,736	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.02
33.03	HOSPITAL BAD DEBT	A	-4,051,145	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.03
33.04	PATIENT PHONES BENEFITS	A	-514	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MARKETING	A	-326,581	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.05
33.06	LOBBYING EXPENSE	A	-3,929	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.06
33.07	PHYSICIAN RECRUITING	A	-33,793	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.07
33.08	CHARITABLE CONTRIBUTIONS	A	-14,393	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.08
33.09	CRNA COSTS	A	-649,296	OPERATING ROOM	50.00	0	33.09
33.10	PENALITIES	A	-1	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.10
33.11	MEDICAL STAFF RELATIONS	A	3,905	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.11
33.12	COUNTRY CLUB DUES	A	-3,725	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.12
33.13	NON-ALLOWABLE LEGAL (DOJ SETTLEMENT)	A	-289,989	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,660,449				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: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-1 Date/Time Prepared: 2/29/2016 1:35 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	DIRECT ALLOC - CAPITAL-RELAT	268,751	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	7,122	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVABLE	11,470	0	3.00
4.00	5.04	OTHER ADMINISTRATIVE AND GEN	PASI OPERATING COSTS	83,122	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BLDG & FIXTURE	6,783	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	45,032	0	4.02
4.03	5.04	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL HOME OFFICE COST	760,787	0	4.03
4.04	5.04	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE COSTS	49,021	130,888	4.04
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	54,285	110,798	4.05
4.06	5.04	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEE	0	810,790	4.06
4.07	5.04	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	1,321	4.07
4.08	5.04	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	20,148	4.08
4.09	5.04	OTHER ADMINISTRATIVE AND GEN	MIS FEES	0	383,321	4.09
4.10	5.04	OTHER ADMINISTRATIVE AND GEN	MANAGED CARE	0	4,084	4.10
4.11	5.04	OTHER ADMINISTRATIVE AND GEN	CASE MANAGEMENT	0	17,887	4.11
4.12	5.04	OTHER ADMINISTRATIVE AND GEN	PURCHASE AND ANCILLIARY	0	1,029	4.12
4.13	91.00	EMERGENCY	EMERGENCY ROOM	0	10,700	4.13
4.14	5.04	OTHER ADMINISTRATIVE AND GEN	PPSI FEES	0	24,420	4.14
4.15	5.04	OTHER ADMINISTRATIVE AND GEN	COMPLIANCE	0	4,761	4.15
4.16	5.04	OTHER ADMINISTRATIVE AND GEN	SENIOR CIRCLE	0	3,443	4.16
4.17	5.04	OTHER ADMINISTRATIVE AND GEN	PASI COLLECTION FEES	0	149,844	4.17
4.18	5.04	OTHER ADMINISTRATIVE AND GEN	PASI LIEN UNIT	0	22,132	4.18
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,286,373	1,695,566	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office: Name	Related Organization(s) and/or Home Office: 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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B	CHS, INC.	100.00	CHS, INC.	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: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 2/29/2016 1:35 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	268,751	11	1.00
2.00	7,122	14	2.00
3.00	11,470	14	3.00
4.00	83,122	0	4.00
4.01	6,783	14	4.01
4.02	45,032	14	4.02
4.03	760,787	0	4.03
4.04	-81,867	0	4.04
4.05	-56,513	14	4.05
4.06	-810,790	0	4.06
4.07	-1,321	0	4.07
4.08	-20,148	0	4.08
4.09	-383,321	0	4.09
4.10	-4,084	0	4.10
4.11	-17,887	0	4.11
4.12	-1,029	0	4.12
4.13	-10,700	0	4.13
4.14	-24,420	0	4.14
4.15	-4,761	0	4.15
4.16	-3,443	0	4.16
4.17	-149,844	0	4.17
4.18	-22,132	0	4.18
5.00	-409,193		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.

	Type of Business		
6.00	HOSPITAL MANAGE		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: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 2/29/2016 1:35 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	109,690	109,690	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	44,250	0	44,250	159,800	354	2.00
3.00	91.00	EMERGENCY	205,453	205,453	0	0	0	3.00
4.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	13,763	13,763	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			373,156	328,906	44,250		354	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	27,197	1,360	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			27,197	1,360	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	109,690		1.00
2.00	13.00	NURSING ADMINISTRATION	0	27,197	17,053	17,053		2.00
3.00	91.00	EMERGENCY	0	0	0	205,453		3.00
4.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	13,763		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	27,197	17,053	345,959		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/29/2016 1:35 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	WELLS CRC COSTS-BLDG & FIXT	MVBLE EQUIP		
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,426,758	2,426,758				1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	127,117	0	127,117			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,993,866			1,993,866		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,283,703	0	1,627	13,415	2,298,745	4.00
5.01	01160	COMMUNICATIONS	385,804	12,183	0	8,611	6,845	5.01
5.02	00540	ADMITTING	362,999	16,149	0	11,415	61,049	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	1,017,438	23,785	0	16,812	29,430	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	4,540,594	200,507	814	148,435	151,815	5.04
7.00	00700	OPERATION OF PLANT	1,870,440	140,657	0	99,423	59,685	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	131,482	2,372	2,903	25,607	0	8.00
9.00	00900	HOUSEKEEPING	387,720	10,020	0	7,083	48,189	9.00
10.00	01000	DIETARY	155,619	98,437	0	69,580	18,319	10.00
11.00	01100	CAFETERIA	540,853	0	3,737	30,812	67,883	11.00
13.00	01300	NURSING ADMINISTRATION	1,102,656	4,942	0	3,493	192,749	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	476,918	122,049	0	86,270	12,902	14.00
15.00	01500	PHARMACY	704,235	0	0	0	100,656	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	516,704	29,011	0	20,506	79,801	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,786,814	206,104	0	145,684	285,359	30.00
31.00	03100	INTENSIVE CARE UNIT	742,388	36,313	0	25,668	128,720	31.00
43.00	04300	NURSERY	267,260	6,042	0	4,271	40,550	43.00
44.00	04400	SKILLED NURSING FACILITY	695,736	73,726	0	52,113	116,212	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,198,896	193,971	0	137,108	170,213	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	177,467	7,117	0	5,031	26,926	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,079,674	135,035	0	95,449	171,630	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	138,161	8,797	0	6,218	12,792	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	1,465,554	55,922	0	39,528	124,698	60.00
65.00	06500	RESPIRATORY THERAPY	415,767	65,596	0	46,366	72,176	65.00
66.00	06600	PHYSICAL THERAPY	724,542	60,876	0	43,030	123,339	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	187,659	0	1,373	11,319	31,609	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	50,365	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	616,939	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	926,746	18,101	1,552	25,589	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	37,089	4,287	0	3,031	4,024	76.01
76.03	03953	WOUND CARE	109,967	0	0	0	16,666	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	64,898	13,270	0	9,380	9,703	90.00
91.00	09100	EMERGENCY	807,444	58,788	0	41,554	123,279	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,518,272	1,604,057	12,006	1,232,801	2,287,219	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35,575	11,404	0	8,061	369	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	740,524	17,297	666,036	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	43,751	0	30,925	0	194.00
194.01	07955	MARKETING	217,943	27,022	0	19,100	10,373	194.01
194.02	07952	SENIOR CIRCLE	5,693	0	0	0	784	194.02
194.03	07953	BUSINESS HEALTH	734	0	4,481	36,943	0	194.03
194.04	07954	VACANT SPACE	0	0	93,333	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	30,778,217	2,426,758	127,117	1,993,866	2,298,745	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/29/2016 1:35 pm

		Cost Center Description	COMMUNICATIONS	Subtotal	ADMITTING	Subtotal	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5A.01	5.02	5A.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS	413,443					5.01
5.02	00540	ADMITTING	6,748	458,360	458,360			5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	4,907	1,092,372	16,513	1,108,885	1,108,885	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	31,898	5,074,063	76,719	5,150,782	192,507	5.04
7.00	00700	OPERATION OF PLANT	7,361	2,177,566	32,918	2,210,484	82,617	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	613	162,977	2,464	165,441	6,183	8.00
9.00	00900	HOUSEKEEPING	1,227	454,239	6,867	461,106	17,234	9.00
10.00	01000	DIETARY	5,521	347,476	5,253	352,729	13,183	10.00
11.00	01100	CAFETERIA	0	643,285	9,725	653,010	24,406	11.00
13.00	01300	NURSING ADMINISTRATION	1,840	1,305,680	19,738	1,325,418	49,537	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,067	701,206	10,600	711,806	26,604	14.00
15.00	01500	PHARMACY	6,748	811,639	12,270	823,909	30,794	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,335	661,357	9,998	671,355	25,092	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,268	2,436,229	36,828	2,473,057	92,431	30.00
31.00	03100	INTENSIVE CARE UNIT	3,067	936,156	14,152	950,308	35,518	31.00
43.00	04300	NURSERY	613	318,736	4,818	323,554	12,093	43.00
44.00	04400	SKILLED NURSING FACILITY	6,134	943,921	14,269	958,190	35,812	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,856	1,721,044	26,017	1,747,061	65,296	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,227	217,768	3,292	221,060	8,262	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,882	1,494,670	22,595	1,517,265	56,708	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	1,227	167,195	2,527	169,722	6,343	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	11,655	1,697,357	25,659	1,723,016	64,398	60.00
65.00	06500	RESPIRATORY THERAPY	1,840	601,745	9,097	610,842	22,830	65.00
66.00	06600	PHYSICAL THERAPY	3,067	954,854	14,435	969,289	36,227	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	3,681	235,641	3,562	239,203	8,940	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	50,365	761	51,126	1,911	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	616,939	9,326	626,265	23,407	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	971,988	14,694	986,682	36,877	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	48,431	732	49,163	1,837	76.01
76.03	03953	WOUND CARE	0	126,633	1,914	128,547	4,804	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,067	100,318	1,517	101,835	3,806	90.00
91.00	09100	EMERGENCY	10,428	1,041,493	15,744	1,057,237	39,514	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	177,277	28,571,703	425,004	28,538,347	1,025,171	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,454	57,863	875	58,738	2,195	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	233,712	1,657,569	25,057	1,682,626	62,888	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	74,676	1,129	75,805	2,833	194.00
194.01	07955	MARKETING	0	274,438	4,149	278,587	10,412	194.01
194.02	07952	SENIOR CIRCLE	0	6,477	98	6,575	246	194.02
194.03	07953	BUSINESS HEALTH	0	42,158	637	42,795	1,599	194.03
194.04	07954	VACANT SPACE	0	93,333	1,411	94,744	3,541	194.04
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	413,443	30,778,217	458,360	30,778,217	1,108,885	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/29/2016 1:35 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.04	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	5,343,289					5.04
7.00	00700	OPERATION OF PLANT	0	2,293,101				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	34,627	206,251			8.00
9.00	00900	HOUSEKEEPING	0	9,578	12	487,930		9.00
10.00	01000	DIETARY	0	94,090	0	20,414	480,416	10.00
11.00	01100	CAFETERIA	0	41,666	0	9,040	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,724	0	1,025	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	116,659	8,776	25,311	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,730	0	6,016	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	386,768	197,003	77,641	42,743	294,962	30.00
31.00	03100	INTENSIVE CARE UNIT	92,938	34,710	12,086	7,531	33,282	31.00
43.00	04300	NURSERY	26,653	5,775	0	1,253	0	43.00
44.00	04400	SKILLED NURSING FACILITY	90,657	70,470	23,238	15,290	152,172	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	917,758	185,405	35,751	40,226	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,698	6,803	0	1,476	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	983,608	129,072	17,483	28,004	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	32,793	8,409	0	1,824	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	1,003,856	53,452	0	11,597	0	60.00
65.00	06500	RESPIRATORY THERAPY	147,521	62,699	146	13,604	0	65.00
66.00	06600	PHYSICAL THERAPY	196,069	58,188	2,775	12,625	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	57,835	15,306	0	3,321	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	243,158	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	158,600	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	425,059	34,603	0	7,508	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	16,542	4,098	30	889	0	76.01
76.03	03953	WOUND CARE	31,519	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,494	12,684	0	2,752	0	90.00
91.00	09100	EMERGENCY	503,763	56,192	28,313	12,192	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,343,289	1,263,943	206,251	264,641	480,416	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,901	0	2,365	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	900,654	0	195,408	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	41,819	0	9,073	0	194.00
194.01	07955	MARKETING	0	25,828	0	5,604	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	0	49,956	0	10,839	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	5,343,289	2,293,101	206,251	487,930	480,416	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/29/2016 1:35 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
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	728,122					11.00
13.00	01300	NURSING ADMINISTRATION	51,378	1,432,082				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,406	0	897,562			14.00
15.00	01500	PHARMACY	26,890	0	27,001	908,594		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,157	0	2,583	0	774,933	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	127,458	527,269	81,349	0	56,090	30.00
31.00	03100	INTENSIVE CARE UNIT	42,200	237,840	16,331	0	13,478	31.00
43.00	04300	NURSERY	14,281	74,926	0	0	3,865	43.00
44.00	04400	SKILLED NURSING FACILITY	51,635	0	15,941	0	13,147	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,873	314,508	110,757	0	133,096	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,478	49,753	0	0	2,567	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,528	0	33,818	0	142,646	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	3,817	0	866	0	4,756	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	63,171	0	106,422	0	145,617	60.00
65.00	06500	RESPIRATORY THERAPY	28,605	0	7,361	0	21,394	65.00
66.00	06600	PHYSICAL THERAPY	45,202	0	16,417	0	28,434	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	21,872	0	0	0	8,387	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	70,966	0	35,263	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	332,718	0	23,001	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	908,594	61,643	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	2,230	0	4,471	0	2,399	76.01
76.03	03953	WOUND CARE	7,162	0	13,605	0	4,571	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,530	0	5,631	0	1,522	90.00
91.00	09100	EMERGENCY	46,789	227,786	39,996	0	73,057	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	723,662	1,432,082	886,233	908,594	774,933	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	214	0	8,739	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	3,817	0	2,590	0	0	194.01
194.02	07952	SENIOR CIRCLE	429	0	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	728,122	1,432,082	897,562	908,594	774,933	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/29/2016 1:35 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00540	ADMITTING					5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL					5.04
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,356,771	0	4,356,771		30.00
31.00	03100	INTENSIVE CARE UNIT	1,476,222	0	1,476,222		31.00
43.00	04300	NURSERY	462,400	0	462,400		43.00
44.00	04400	SKILLED NURSING FACILITY	1,426,552	0	1,426,552		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,615,731	0	3,615,731		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	317,097	0	317,097		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,971,132	0	2,971,132		54.00
54.01	03630	ULTRA SOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	228,530	0	228,530		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	3,171,529	0	3,171,529		60.00
65.00	06500	RESPIRATORY THERAPY	915,002	0	915,002		65.00
66.00	06600	PHYSICAL THERAPY	1,365,226	0	1,365,226		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	354,864	0	354,864		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	402,424	0	402,424		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,163,991	0	1,163,991		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,460,966	0	2,460,966		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0		76.00
76.01	03951	SLEEP LAB	81,659	0	81,659		76.01
76.03	03953	WOUND CARE	190,208	0	190,208		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	141,254	0	141,254		90.00
91.00	09100	EMERGENCY	2,084,839	0	2,084,839		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,186,397	0	27,186,397		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	83,152	0	83,152		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,841,576	0	2,841,576		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	129,530	0	129,530		194.00
194.01	07955	MARKETING	326,838	0	326,838		194.01
194.02	07952	SENIOR CIRCLE	7,250	0	7,250		194.02
194.03	07953	BUSINESS HEALTH	105,189	0	105,189		194.03
194.04	07954	VACANT SPACE	98,285	0	98,285		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	30,778,217	0	30,778,217		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/29/2016 1:35 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	WELLS CRC COSTS-BLDG & FIXT	MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,627	13,415	15,042	4.00
5.01	01160	COMMUNICATIONS	0	12,183	0	8,611	20,794	5.01
5.02	00540	ADMITTING	0	16,149	0	11,415	27,564	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	23,785	0	16,812	40,597	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	200,507	814	148,435	349,756	5.04
7.00	00700	OPERATION OF PLANT	0	140,657	0	99,423	240,080	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,372	2,903	25,607	30,882	8.00
9.00	00900	HOUSEKEEPING	0	10,020	0	7,083	17,103	9.00
10.00	01000	DIETARY	0	98,437	0	69,580	168,017	10.00
11.00	01100	CAFETERIA	0	0	3,737	30,812	34,549	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,942	0	3,493	8,435	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	122,049	0	86,270	208,319	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,011	0	20,506	49,517	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	206,104	0	145,684	351,788	30.00
31.00	03100	INTENSIVE CARE UNIT	0	36,313	0	25,668	61,981	31.00
43.00	04300	NURSERY	0	6,042	0	4,271	10,313	43.00
44.00	04400	SKILLED NURSING FACILITY	0	73,726	0	52,113	125,839	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	193,971	0	137,108	331,079	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,117	0	5,031	12,148	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	135,035	0	95,449	230,484	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	8,797	0	6,218	15,015	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	55,922	0	39,528	95,450	60.00
65.00	06500	RESPIRATORY THERAPY	0	65,596	0	46,366	111,962	65.00
66.00	06600	PHYSICAL THERAPY	0	60,876	0	43,030	103,906	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	1,373	11,319	12,692	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	18,101	1,552	25,589	45,242	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	4,287	0	3,031	7,318	76.01
76.03	03953	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	13,270	0	9,380	22,650	90.00
91.00	09100	EMERGENCY	0	58,788	0	41,554	100,342	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,604,057	12,006	1,232,801	2,848,864	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,404	0	8,061	19,465	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	740,524	17,297	666,036	1,423,857	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	43,751	0	30,925	74,676	194.00
194.01	07955	MARKETING	0	27,022	0	19,100	46,122	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	0	0	4,481	36,943	41,424	194.03
194.04	07954	VACANT SPACE	0	0	93,333	0	93,333	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	2,426,758	127,117	1,993,866	4,547,741	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/29/2016 1:35 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
			4.00	5.01	5.02	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	15,042					4.00
5.01	01160	COMMUNICATIONS	45	20,839				5.01
5.02	00540	ADMITTING	399	340	28,303			5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	193	247	1,019	42,056		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	993	1,608	4,748	7,317	364,422	5.04
7.00	00700	OPERATION OF PLANT	391	371	2,032	3,132	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	31	152	234	0	8.00
9.00	00900	HOUSEKEEPING	315	62	424	653	0	9.00
10.00	01000	DIETARY	120	278	324	500	0	10.00
11.00	01100	CAFETERIA	444	0	600	925	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,261	93	1,218	1,878	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	84	155	654	1,009	0	14.00
15.00	01500	PHARMACY	659	340	757	1,167	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	522	773	617	951	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,870	618	2,273	3,504	26,373	30.00
31.00	03100	INTENSIVE CARE UNIT	842	155	873	1,347	6,337	31.00
43.00	04300	NURSERY	265	31	297	458	1,817	43.00
44.00	04400	SKILLED NURSING FACILITY	760	309	881	1,358	6,182	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,114	1,051	1,606	2,476	62,580	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	176	62	203	313	1,207	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,123	649	1,395	2,150	67,071	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	84	62	156	240	2,236	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	816	587	1,584	2,442	68,522	60.00
65.00	06500	RESPIRATORY THERAPY	472	93	561	866	10,059	65.00
66.00	06600	PHYSICAL THERAPY	807	155	891	1,373	13,370	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	207	186	220	339	3,944	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	47	72	16,581	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	576	887	10,815	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	907	1,398	28,984	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	26	0	45	70	1,128	76.01
76.03	03953	WOUND CARE	109	0	118	182	2,149	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	63	155	94	144	716	90.00
91.00	09100	EMERGENCY	807	526	972	1,498	34,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,967	8,937	26,244	38,883	364,422	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2	124	54	83	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,778	1,547	2,384	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	70	107	0	194.00
194.01	07955	MARKETING	68	0	256	395	0	194.01
194.02	07952	SENIOR CIRCLE	5	0	6	9	0	194.02
194.03	07953	BUSINESS HEALTH	0	0	39	61	0	194.03
194.04	07954	VACANT SPACE	0	0	87	134	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	15,042	20,839	28,303	42,056	364,422	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/29/2016 1:35 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT	246,006					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,715	35,014				8.00
9.00	00900	HOUSEKEEPING	1,028	2	19,587			9.00
10.00	01000	DIETARY	10,094	0	819	180,152		10.00
11.00	01100	CAFETERIA	4,470	0	363	0	41,351	11.00
13.00	01300	NURSING ADMINISTRATION	507	0	41	0	2,918	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,515	1,490	1,016	0	477	14.00
15.00	01500	PHARMACY	0	0	0	0	1,527	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,975	0	242	0	2,394	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,135	13,180	1,716	110,608	7,238	30.00
31.00	03100	INTENSIVE CARE UNIT	3,724	2,052	302	12,481	2,397	31.00
43.00	04300	NURSERY	620	0	50	0	811	43.00
44.00	04400	SKILLED NURSING FACILITY	7,560	3,945	614	57,063	2,932	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,890	6,069	1,615	0	3,741	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	730	0	59	0	538	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,847	2,968	1,124	0	3,551	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	902	0	73	0	217	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	5,734	0	466	0	3,588	60.00
65.00	06500	RESPIRATORY THERAPY	6,726	25	546	0	1,625	65.00
66.00	06600	PHYSICAL THERAPY	6,242	471	507	0	2,567	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	1,642	0	133	0	1,242	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	3,712	0	301	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	440	5	36	0	127	76.01
76.03	03953	WOUND CARE	0	0	0	0	407	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,361	0	110	0	144	90.00
91.00	09100	EMERGENCY	6,028	4,807	489	0	2,657	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	135,597	35,014	10,622	180,152	41,098	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,169	0	95	0	12	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	96,624	0	7,846	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	4,486	0	364	0	0	194.00
194.01	07955	MARKETING	2,771	0	225	0	217	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	24	194.02
194.03	07953	BUSINESS HEALTH	5,359	0	435	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	246,006	35,014	19,587	180,152	41,351	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/29/2016 1:35 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	16,351					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	225,719				14.00
15.00	01500	PHARMACY	0	6,790	11,240			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	650	0	58,641		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,020	20,458	0	4,247	571,028	30.00
31.00	03100	INTENSIVE CARE UNIT	2,716	4,107	0	1,020	100,334	31.00
43.00	04300	NURSERY	855	0	0	293	15,810	43.00
44.00	04400	SKILLED NURSING FACILITY	0	4,009	0	995	212,447	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,591	27,853	0	10,077	472,742	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	568	0	0	194	16,198	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,505	0	10,800	343,667	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	218	0	360	19,563	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	26,763	0	10,994	216,946	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,851	0	1,620	136,406	65.00
66.00	06600	PHYSICAL THERAPY	0	4,129	0	2,153	136,571	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	635	21,240	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	17,847	0	2,670	37,217	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	83,671	0	1,741	97,690	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	11,240	4,667	96,451	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	1,124	0	182	10,501	76.01
76.03	03953	WOUND CARE	0	3,421	0	346	6,732	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,416	0	115	26,968	90.00
91.00	09100	EMERGENCY	2,601	10,058	0	5,532	170,668	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,351	222,870	11,240	58,641	2,709,179	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,198	0	0	23,202	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,544,036	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	79,703	194.00
194.01	07955	MARKETING	0	651	0	0	50,705	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	44	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	47,318	194.03
194.04	07954	VACANT SPACE	0	0	0	0	93,554	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	16,351	225,719	11,240	58,641	4,547,741	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/29/2016 1:35 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	01160	COMMUNICATIONS			5.01
5.02	00540	ADMITTING			5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL			5.04
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	571,028	30.00
31.00	03100	INTENSIVE CARE UNIT	0	100,334	31.00
43.00	04300	NURSERY	0	15,810	43.00
44.00	04400	SKILLED NURSING FACILITY	0	212,447	44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	472,742	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	16,198	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	343,667	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	19,563	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	216,946	60.00
65.00	06500	RESPIRATORY THERAPY	0	136,406	65.00
66.00	06600	PHYSICAL THERAPY	0	136,571	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	21,240	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	37,217	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	97,690	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	96,451	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.01	03951	SLEEP LAB	0	10,501	76.01
76.03	03953	WOUND CARE	0	6,732	76.03
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	26,968	90.00
91.00	09100	EMERGENCY	0	170,668	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0	95.00
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,709,179	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,202	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,544,036	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	79,703	194.00
194.01	07955	MARKETING	0	50,705	194.01
194.02	07952	SENIOR CIRCLE	0	44	194.02
194.03	07953	BUSINESS HEALTH	0	47,318	194.03
194.04	07954	VACANT SPACE	0	93,554	194.04
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	4,547,741	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/29/2016 1:35 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	WELLS CRC COSTS-BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NONPATIENT PHONES)	
			1.00	1.01	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	196,409					1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	0	119,997				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			228,300			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,536	1,536	11,696,913		4.00
5.01	01160	COMMUNICATIONS	986	0	986	34,832	674	5.01
5.02	00540	ADMITTING	1,307	0	1,307	310,641	11	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	1,925	0	1,925	149,751	8	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	16,228	768	16,996	772,493	52	5.04
7.00	00700	OPERATION OF PLANT	11,384	0	11,384	303,702	12	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	192	2,740	2,932	0	1	8.00
9.00	00900	HOUSEKEEPING	811	0	811	245,204	2	9.00
10.00	01000	DIETARY	7,967	0	7,967	93,214	9	10.00
11.00	01100	CAFETERIA	0	3,528	3,528	345,414	0	11.00
13.00	01300	NURSING ADMINISTRATION	400	0	400	980,782	3	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,878	0	9,878	65,652	5	14.00
15.00	01500	PHARMACY	0	0	0	512,178	11	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,348	0	2,348	406,056	25	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,681	0	16,681	1,452,022	20	30.00
31.00	03100	INTENSIVE CARE UNIT	2,939	0	2,939	654,976	5	31.00
43.00	04300	NURSERY	489	0	489	206,335	1	43.00
44.00	04400	SKILLED NURSING FACILITY	5,967	0	5,967	591,333	10	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,699	0	15,699	866,109	34	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	576	0	576	137,011	2	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,929	0	10,929	873,322	21	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	712	0	712	65,090	2	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	4,526	0	4,526	634,513	19	60.00
65.00	06500	RESPIRATORY THERAPY	5,309	0	5,309	367,258	3	65.00
66.00	06600	PHYSICAL THERAPY	4,927	0	4,927	627,594	5	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	1,296	1,296	160,837	6	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	1,465	1,465	2,930	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	347	0	347	20,477	0	76.01
76.03	03953	WOUND CARE	0	0	0	84,805	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,074	0	1,074	49,374	5	90.00
91.00	09100	EMERGENCY	4,758	0	4,758	627,289	17	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	129,824	11,333	141,157	11,638,264	289	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	923	0	923	1,878	4	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,934	16,328	76,262	0	381	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	3,541	0	3,541	0	0	194.00
194.01	07955	MARKETING	2,187	0	2,187	52,781	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	3,990	0	194.02
194.03	07953	BUSINESS HEALTH	0	4,230	4,230	0	0	194.03
194.04	07954	VACANT SPACE	0	88,106	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,426,758	127,117	1,993,866	2,298,745	413,443	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.355635	1.059335	8.733535	0.196526	613.416914	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				15,042	20,839	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.001286	30.918398	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/29/2016 1:35 pm

		Cost Center Description	Reconciliation	ADMITTING (ACCUM. COST)	Reconciliation	CASHIERING/ACCOUNTS RECEIVABLE (ACCUM. COST)	OTHER ADMINISTRATIVE AND GENERAL (GROSS CHARGES)	
			5A.02	5.02	5A.03	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING	-458,360	30,319,857				5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	1,092,372	-1,108,885	29,669,332		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	5,074,063	0	5,150,782	153,994,994	5.04
7.00	00700	OPERATION OF PLANT	0	2,177,566	0	2,210,484	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	162,977	0	165,441	0	8.00
9.00	00900	HOUSEKEEPING	0	454,239	0	461,106	0	9.00
10.00	01000	DIETARY	0	347,476	0	352,729	0	10.00
11.00	01100	CAFETERIA	0	643,285	0	653,010	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,305,680	0	1,325,418	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	701,206	0	711,806	0	14.00
15.00	01500	PHARMACY	0	811,639	0	823,909	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	661,357	0	671,355	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,436,229	0	2,473,057	11,146,705	30.00
31.00	03100	INTENSIVE CARE UNIT	0	936,156	0	950,308	2,678,473	31.00
43.00	04300	NURSERY	0	318,736	0	323,554	768,137	43.00
44.00	04400	SKILLED NURSING FACILITY	0	943,921	0	958,190	2,612,744	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,721,044	0	1,747,061	26,449,868	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	217,768	0	221,060	510,061	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,494,670	0	1,517,265	28,347,681	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	167,195	0	169,722	945,091	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	1,697,357	0	1,723,016	28,932,141	60.00
65.00	06500	RESPIRATORY THERAPY	0	601,745	0	610,842	4,251,569	65.00
66.00	06600	PHYSICAL THERAPY	0	954,854	0	969,289	5,650,726	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	235,641	0	239,203	1,666,800	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	50,365	0	51,126	7,007,837	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	616,939	0	626,265	4,570,861	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	971,988	0	986,682	12,250,238	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	48,431	0	49,163	476,734	76.01
76.03	03953	WOUND CARE	0	126,633	0	128,547	908,385	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	100,318	0	101,835	302,449	90.00
91.00	09100	EMERGENCY	0	1,041,493	0	1,057,237	14,518,494	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	-458,360	28,113,343	-1,108,885	27,429,462	153,994,994	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	57,863	0	58,738	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,657,569	0	1,682,626	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	74,676	0	75,805	0	194.00
194.01	07955	MARKETING	0	274,438	0	278,587	0	194.01
194.02	07952	SENIOR CIRCLE	0	6,477	0	6,575	0	194.02
194.03	07953	BUSINESS HEALTH	0	42,158	0	42,795	0	194.03
194.04	07954	VACANT SPACE	0	93,333	0	94,744	0	194.04
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)		458,360		1,108,885	5,343,289	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.015117		0.037375	0.034698	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		28,303		42,056	364,422	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000933		0.001417	0.002366	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/29/2016 1:35 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT	194,166					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,932	285,475				8.00
9.00	00900	HOUSEKEEPING	811	16	190,423			9.00
10.00	01000	DIETARY	7,967	0	7,967	34,311		10.00
11.00	01100	CAFETERIA	3,528	0	3,528	0	16,978	11.00
13.00	01300	NURSING ADMINISTRATION	400	0	400	0	1,198	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,878	12,147	9,878	0	196	14.00
15.00	01500	PHARMACY	0	0	0	0	627	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,348	0	2,348	0	983	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,681	107,465	16,681	21,066	2,972	30.00
31.00	03100	INTENSIVE CARE UNIT	2,939	16,729	2,939	2,377	984	31.00
43.00	04300	NURSERY	489	0	489	0	333	43.00
44.00	04400	SKILLED NURSING FACILITY	5,967	32,164	5,967	10,868	1,204	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,699	49,483	15,699	0	1,536	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	576	0	576	0	221	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,929	24,198	10,929	0	1,458	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	712	0	712	0	89	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	4,526	0	4,526	0	1,473	60.00
65.00	06500	RESPIRATORY THERAPY	5,309	202	5,309	0	667	65.00
66.00	06600	PHYSICAL THERAPY	4,927	3,841	4,927	0	1,054	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	1,296	0	1,296	0	510	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	2,930	0	2,930	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	347	41	347	0	52	76.01
76.03	03953	WOUND CARE	0	0	0	0	167	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,074	0	1,074	0	59	90.00
91.00	09100	EMERGENCY	4,758	39,189	4,758	0	1,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	107,023	285,475	103,280	34,311	16,874	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	923	0	923	0	5	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	76,262	0	76,262	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	3,541	0	3,541	0	0	194.00
194.01	07955	MARKETING	2,187	0	2,187	0	89	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	10	194.02
194.03	07953	BUSINESS HEALTH	4,230	0	4,230	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,293,101	206,251	487,930	480,416	728,122	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.810003	0.722484	2.562348	14.001807	42.886206	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	246,006	35,014	19,587	180,152	41,351	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.266988	0.122652	0.102860	5.250561	2.435564	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/29/2016 1:35 pm

		Cost Center Description	NURSING ADMINISTRATION (FTES IN NURSING AREA)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (% COSTED REQUI)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	3,943,742					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,786,620				14.00
15.00	01500	PHARMACY	0	53,746	982,999			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,141	0	153,994,994		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,452,022	161,928	0	11,146,705		30.00
31.00	03100	INTENSIVE CARE UNIT	654,976	32,507	0	2,678,473		31.00
43.00	04300	NURSERY	206,335	0	0	768,137		43.00
44.00	04400	SKILLED NURSING FACILITY	0	31,731	0	2,612,744		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	866,109	220,465	0	26,449,868		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	137,011	0	0	510,061		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	67,315	0	28,347,681		54.00
54.01	03630	ULTRA SOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	1,723	0	945,091		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	211,835	0	28,932,141		60.00
65.00	06500	RESPIRATORY THERAPY	0	14,653	0	4,251,569		65.00
66.00	06600	PHYSICAL THERAPY	0	32,678	0	5,650,726		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,666,800		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	141,260	0	7,007,837		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	662,284	0	4,570,861		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	982,999	12,250,238		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0		76.00
76.01	03951	SLEEP LAB	0	8,900	0	476,734		76.01
76.03	03953	WOUND CARE	0	27,081	0	908,385		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	11,209	0	302,449		90.00
91.00	09100	EMERGENCY	627,289	79,614	0	14,518,494		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,943,742	1,764,070	982,999	153,994,994		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,395	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0		194.00
194.01	07955	MARKETING	0	5,155	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0		194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0		194.03
194.04	07954	VACANT SPACE	0	0	0	0		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,432,082	897,562	908,594	774,933		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.363128	0.502380	0.924308	0.005032		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	16,351	225,719	11,240	58,641		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004146	0.126339	0.011434	0.000381		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I | Date/Time Prepared: 2/29/2016 1:35 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	4,356,771		4,356,771	0	4,356,771	30.00
31.00	03100	INTENSIVE CARE UNIT	1,476,222		1,476,222	0	1,476,222	31.00
43.00	04300	NURSERY	462,400		462,400	0	462,400	43.00
44.00	04400	SKILLED NURSING FACILITY	1,426,552		1,426,552	0	1,426,552	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,615,731		3,615,731	0	3,615,731	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	317,097		317,097	0	317,097	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,971,132		2,971,132	0	2,971,132	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	228,530		228,530	0	228,530	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	3,171,529		3,171,529	0	3,171,529	60.00
65.00	06500	RESPIRATORY THERAPY	915,002	0	915,002	0	915,002	65.00
66.00	06600	PHYSICAL THERAPY	1,365,226	0	1,365,226	0	1,365,226	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	354,864		354,864	0	354,864	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	402,424		402,424	0	402,424	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,163,991		1,163,991	0	1,163,991	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,460,966		2,460,966	0	2,460,966	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.01	03951	SLEEP LAB	81,659		81,659	0	81,659	76.01
76.03	03953	WOUND CARE	190,208		190,208	0	190,208	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	141,254		141,254	0	141,254	90.00
91.00	09100	EMERGENCY	2,084,839		2,084,839	0	2,084,839	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	937,331		937,331		937,331	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	28,123,728	0	28,123,728	0	28,123,728	200.00
201.00		Less Observation Beds	937,331		937,331		937,331	201.00
202.00		Total (see instructions)	27,186,397	0	27,186,397	0	27,186,397	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/29/2016 1:35 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,375,061		9,375,061			30.00
31.00	03100	INTENSIVE CARE UNIT	2,678,473		2,678,473			31.00
43.00	04300	NURSERY	768,137		768,137			43.00
44.00	04400	SKILLED NURSING FACILITY	2,612,744		2,612,744			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,793,756	19,656,112	26,449,868	0.136701	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	391,264	118,797	510,061	0.621684	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,057,274	23,290,407	28,347,681	0.104810	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	163,772	781,319	945,091	0.241807	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	7,606,944	21,325,197	28,932,141	0.109620	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,987,073	264,496	4,251,569	0.215215	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,616,558	3,034,168	5,650,726	0.241602	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	768,215	898,585	1,666,800	0.212901	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,833,143	3,174,694	7,007,837	0.057425	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,358,962	2,211,899	4,570,861	0.254655	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,167,347	7,082,891	12,250,238	0.200891	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	2,400	474,334	476,734	0.171288	0.000000	76.01
76.03	03953	WOUND CARE	2,268	906,117	908,385	0.209391	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	61,452	240,997	302,449	0.467034	0.000000	90.00
91.00	09100	EMERGENCY	2,989,798	11,528,696	14,518,494	0.143599	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	147,912	1,623,732	1,771,644	0.529074	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	57,382,553	96,612,441	153,994,994			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	57,382,553	96,612,441	153,994,994			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/29/2016 1:35 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
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.136701	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.621684	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104810	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.241807	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.109620	60.00
65.00	06500	RESPIRATORY THERAPY	0.215215	65.00
66.00	06600	PHYSICAL THERAPY	0.241602	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.212901	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.057425	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.254655	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200891	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	76.00
76.01	03951	SLEEP LAB	0.171288	76.01
76.03	03953	WOUND CARE	0.209391	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.467034	90.00
91.00	09100	EMERGENCY	0.143599	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.529074	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
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: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I | Date/Time Prepared: 2/29/2016 1:35 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	4,356,771		4,356,771	0	4,356,771	30.00
31.00	03100	INTENSIVE CARE UNIT	1,476,222		1,476,222	0	1,476,222	31.00
43.00	04300	NURSERY	462,400		462,400	0	462,400	43.00
44.00	04400	SKILLED NURSING FACILITY	1,426,552		1,426,552	0	1,426,552	44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,615,731		3,615,731	0	3,615,731	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	317,097		317,097	0	317,097	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,971,132		2,971,132	0	2,971,132	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	228,530		228,530	0	228,530	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	3,171,529		3,171,529	0	3,171,529	60.00
65.00	06500	RESPIRATORY THERAPY	915,002	0	915,002	0	915,002	65.00
66.00	06600	PHYSICAL THERAPY	1,365,226	0	1,365,226	0	1,365,226	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	354,864		354,864	0	354,864	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	402,424		402,424	0	402,424	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,163,991		1,163,991	0	1,163,991	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,460,966		2,460,966	0	2,460,966	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.01	03951	SLEEP LAB	81,659		81,659	0	81,659	76.01
76.03	03953	WOUND CARE	190,208		190,208	0	190,208	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	141,254		141,254	0	141,254	90.00
91.00	09100	EMERGENCY	2,084,839		2,084,839	0	2,084,839	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	937,331		937,331		937,331	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	28,123,728	0	28,123,728	0	28,123,728	200.00
201.00		Less Observation Beds	937,331		937,331		937,331	201.00
202.00		Total (see instructions)	27,186,397	0	27,186,397	0	27,186,397	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I | Date/Time Prepared: 2/29/2016 1:35 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	9,375,061		9,375,061			30.00
31.00	03100	INTENSIVE CARE UNIT	2,678,473		2,678,473			31.00
43.00	04300	NURSERY	768,137		768,137			43.00
44.00	04400	SKILLED NURSING FACILITY	2,612,744		2,612,744			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,793,756	19,656,112	26,449,868	0.136701	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	391,264	118,797	510,061	0.621684	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,057,274	23,290,407	28,347,681	0.104810	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	163,772	781,319	945,091	0.241807	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	7,606,944	21,325,197	28,932,141	0.109620	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,987,073	264,496	4,251,569	0.215215	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,616,558	3,034,168	5,650,726	0.241602	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	768,215	898,585	1,666,800	0.212901	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,833,143	3,174,694	7,007,837	0.057425	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,358,962	2,211,899	4,570,861	0.254655	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,167,347	7,082,891	12,250,238	0.200891	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	2,400	474,334	476,734	0.171288	0.000000	76.01
76.03	03953	WOUND CARE	2,268	906,117	908,385	0.209391	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	61,452	240,997	302,449	0.467034	0.000000	90.00
91.00	09100	EMERGENCY	2,989,798	11,528,696	14,518,494	0.143599	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	147,912	1,623,732	1,771,644	0.529074	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	57,382,553	96,612,441	153,994,994			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	57,382,553	96,612,441	153,994,994			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/29/2016 1:35 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
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03630	ULTRA SOUND	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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	76.00
76.01	03951	SLEEP LAB	0.000000	76.01
76.03	03953	WOUND CARE	0.000000	76.03
		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
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
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: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part I Date/Time Prepared: 2/29/2016 1:35 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	571,028	0	571,028	6,498	87.88	30.00
31.00	INTENSIVE CARE UNIT	100,334		100,334	752	133.42	31.00
43.00	NURSERY	15,810		15,810	517	30.58	43.00
44.00	SKILLED NURSING FACILITY	212,447		212,447	2,779	76.45	44.00
200.00	Total (lines 30-199)	899,619		899,619	10,546		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	2,304	202,476	30.00
31.00	INTENSIVE CARE UNIT	391	52,167	31.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	1,604	122,626	44.00
200.00	Total (lines 30-199)	4,299	377,269	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II | Date/Time Prepared: 2/29/2016 1:35 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	472,742	26,449,868	0.017873	1,819,599	32,522	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,198	510,061	0.031757	2,512	80	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	343,667	28,347,681	0.012123	2,084,937	25,276	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	19,563	945,091	0.020700	87,733	1,816	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	216,946	28,932,141	0.007498	3,350,337	25,121	60.00
65.00	06500	RESPIRATORY THERAPY	136,406	4,251,569	0.032084	1,706,014	54,736	65.00
66.00	06600	PHYSICAL THERAPY	136,571	5,650,726	0.024169	207,218	5,008	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,240	1,666,800	0.012743	751,339	9,574	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,217	7,007,837	0.005311	1,489,476	7,911	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	97,690	4,570,861	0.021372	962,504	20,571	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	96,451	12,250,238	0.007873	1,944,728	15,311	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	10,501	476,734	0.022027	2,400	53	76.01
76.03	03953	WOUND CARE	6,732	908,385	0.007411	2,268	17	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	26,968	302,449	0.089165	12,627	1,126	90.00
91.00	09100	EMERGENCY	170,668	14,518,494	0.011755	1,480,509	17,403	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	122,853	1,771,644	0.069344	102,289	7,093	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,932,413	138,560,579		16,006,490	223,618	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part III Date/Time Prepared: 2/29/2016 1:35 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
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
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	6,498	0.00	2,304	0	30.00
31.00	03100	INTENSIVE CARE UNIT	752	0.00	391	0	31.00
43.00	04300	NURSERY	517	0.00	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,779	0.00	1,604	0	44.00
200.00		Total (lines 30-199)	10,546		4,299	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/29/2016 1:35 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.03	03953	WOUND CARE	0	0	0	0	0	76.03
	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
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
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: 150075	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/29/2016 1:35 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	26,449,868	0.000000	0.000000	1,819,599	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	510,061	0.000000	0.000000	2,512	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,347,681	0.000000	0.000000	2,084,937	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	945,091	0.000000	0.000000	87,733	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	28,932,141	0.000000	0.000000	3,350,337	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,251,569	0.000000	0.000000	1,706,014	65.00
66.00	06600	PHYSICAL THERAPY	0	5,650,726	0.000000	0.000000	207,218	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,666,800	0.000000	0.000000	751,339	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,007,837	0.000000	0.000000	1,489,476	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,570,861	0.000000	0.000000	962,504	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,250,238	0.000000	0.000000	1,944,728	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.01	03951	SLEEP LAB	0	476,734	0.000000	0.000000	2,400	76.01
76.03	03953	WOUND CARE	0	908,385	0.000000	0.000000	2,268	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	302,449	0.000000	0.000000	12,627	90.00
91.00	09100	EMERGENCY	0	14,518,494	0.000000	0.000000	1,480,509	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,771,644	0.000000	0.000000	102,289	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	138,560,579			16,006,490	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/29/2016 1:35 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	4,849,644	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,235	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,380,672	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	237,386	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
60.00	06000	LABORATORY	0	2,327,738	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	73,173	0	65.00
66.00	06600	PHYSICAL THERAPY	0	969	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	523,701	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	719,253	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	812,573	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,959,734	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	76.00
76.01	03951	SLEEP LAB	0	114,967	0	76.01
76.03	03953	WOUND CARE	0	294,406	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	58,923	0	90.00
91.00	09100	EMERGENCY	0	2,285,251	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	406,426	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	20,046,051	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/29/2016 1:35 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.136701	4,849,644	0	0	662,951	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.621684	1,235	0	0	768	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104810	5,380,672	0	0	563,948	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.241807	237,386	0	0	57,402	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.109620	2,327,738	0	0	255,167	60.00
65.00	06500	RESPIRATORY THERAPY	0.215215	73,173	0	0	15,748	65.00
66.00	06600	PHYSICAL THERAPY	0.241602	969	0	0	234	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.212901	523,701	0	0	111,496	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.057425	719,253	0	0	41,303	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.254655	812,573	0	0	206,926	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200891	1,959,734	0	568	393,693	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.171288	114,967	0	0	19,692	76.01
76.03	03953	WOUND CARE	0.209391	294,406	0	0	61,646	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.467034	58,923	0	0	27,519	90.00
91.00	09100	EMERGENCY	0.143599	2,285,251	0	0	328,160	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.529074	406,426	0	0	215,029	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		20,046,051	0	568	2,961,682	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		20,046,051	0	568	2,961,682	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/29/2016 1:35 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	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	114	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.01	03951	SLEEP LAB	0	0	76.01
76.03	03953	WOUND CARE	0	0	76.03
		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
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	114	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	114	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150075 | Component CCN: 155373 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/29/2016 1:35 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.03	03953	WOUND CARE	0	0	0	0	0	76.03
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 150075 | Component CCN: 155373 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/29/2016 1:35 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	26,449,868	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	510,061	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,347,681	0.000000	0.000000	42,138	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	945,091	0.000000	0.000000	1,555	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	28,932,141	0.000000	0.000000	250,673	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,251,569	0.000000	0.000000	372,310	65.00
66.00	06600	PHYSICAL THERAPY	0	5,650,726	0.000000	0.000000	1,226,703	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,666,800	0.000000	0.000000	5,878	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,007,837	0.000000	0.000000	266,461	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,570,861	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,250,238	0.000000	0.000000	556,505	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.01	03951	SLEEP LAB	0	476,734	0.000000	0.000000	0	76.01
76.03	03953	WOUND CARE	0	908,385	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	302,449	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	14,518,494	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,771,644	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	138,560,579			2,722,223	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150075 | Component CCN: 155373 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/29/2016 1:35 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	03630	ULTRA SOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0		76.00
76.01	03951	SLEEP LAB	0	0	0		76.01
76.03	03953	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/29/2016 1:35 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.136701	0	385,090	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.621684	0	10,630	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104810	0	685,242	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.241807	0	11,330	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.109620	0	746,370	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.215215	0	8,989	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.241602	0	186,369	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.212901	0	23,137	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.057425	0	29,511	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.254655	0	31,396	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200891	0	120,669	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.171288	0	12,471	0	0	76.01
76.03	03953	WOUND CARE	0.209391	0	8,263	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.467034	0	5,529	0	0	90.00
91.00	09100	EMERGENCY	0.143599	0	508,337	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.529074	0	35,541	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	2,808,874	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	2,808,874	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/29/2016 1:35 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	52,642	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,609	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,820	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	2,740	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	81,817	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,935	0	65.00
66.00	06600	PHYSICAL THERAPY	45,027	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	4,926	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,695	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,995	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,241	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.01	03951	SLEEP LAB	2,136	0	76.01
76.03	03953	WOUND CARE	1,730	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	2,582	0	90.00
91.00	09100	EMERGENCY	72,997	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	18,804	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	399,696	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	399,696	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/29/2016 1:35 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)	6,498	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,498	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.	2,779	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,321	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,304	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)	4,356,771	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)	4,356,771	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	13,735,819	28.00
29.00	Private room charges (excluding swing-bed charges)	3,596,433	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	10,139,386	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.317183	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	1,294.15	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	4,368.54	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)	4,356,771	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)	670.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,544,786	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)	1,544,786	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/29/2016 1:35 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,476,222	752	1,963.06	391	767,556	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)	2,429,306	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,741,648	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)	254,643	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	223,618	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	478,261	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,263,387	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,398	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	670.48	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	937,331	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 Date/Time Prepared: 2/29/2016 1:35 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	571,028	4,356,771	0.131067	937,331	122,853	90.00
91.00	Nursing School cost	0	4,356,771	0.000000	937,331	0	91.00
92.00	Allied health cost	0	4,356,771	0.000000	937,331	0	92.00
93.00	All other Medical Education	0	4,356,771	0.000000	937,331	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

	Provider CCN: 150075 Component CCN: 155373	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/29/2016 1:35 pm
	Title XVIII	Skilled Nursing Facility	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)	2,779	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,779	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.	1,971	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	808	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)	1,604	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)	1,426,552	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)	1,426,552	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	2,611,843	28.00
29.00	Private room charges (excluding swing-bed charges)	1,884,015	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	727,828	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.546186	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	955.87	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	900.78	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	55.09	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	30.09	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	59,307	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,367,245	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150075 | Component CCN: 155373 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/29/2016 1:35 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description	1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	1,367,245	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	491.99	71.00
72.00	Program routine service cost (line 9 x line 71)	789,152	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	789,152	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	789,152	83.00
84.00	Program inpatient ancillary services (see instructions)	537,122	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	1,326,274	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: 150075 Component CCN: 155373	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/29/2016 1:35 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/29/2016 1:35 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		4,081,035		30.00
31.00	03100	INTENSIVE CARE UNIT		1,529,347		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.136701	1,819,599	248,741	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.621684	2,512	1,562	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104810	2,084,937	218,522	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.241807	87,733	21,214	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.109620	3,350,337	367,264	60.00
65.00	06500	RESPIRATORY THERAPY	0.215215	1,706,014	367,160	65.00
66.00	06600	PHYSICAL THERAPY	0.241602	207,218	50,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.212901	751,339	159,961	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.057425	1,489,476	85,533	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.254655	962,504	245,106	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200891	1,944,728	390,678	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.171288	2,400	411	76.01
76.03	03953	WOUND CARE	0.209391	2,268	475	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.467034	12,627	5,897	90.00
91.00	09100	EMERGENCY	0.143599	1,480,509	212,600	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.529074	102,289	54,118	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		16,006,490	2,429,306	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)		16,006,490		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3

Component CCN: 155373 | Date/Time Prepared: 2/29/2016 1:35 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.136701	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.621684	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104810	42,138	4,416	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.241807	1,555	376	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.109620	250,673	27,479	60.00
65.00	06500	RESPIRATORY THERAPY	0.215215	372,310	80,127	65.00
66.00	06600	PHYSICAL THERAPY	0.241602	1,226,703	296,374	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.212901	5,878	1,251	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.057425	266,461	15,302	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.254655	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200891	556,505	111,797	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.171288	0	0	76.01
76.03	03953	WOUND CARE	0.209391	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.467034	0	0	90.00
91.00	09100	EMERGENCY	0.143599	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.529074	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,722,223	537,122	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		2,722,223		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/29/2016 1:35 pm

Title XIX | Hospital | Cost

		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		252,285		30.00
31.00	03100	INTENSIVE CARE UNIT		22,682		31.00
43.00	04300	NURSERY		60,075		43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.136701	94,579	12,929	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.621684	24,533	15,252	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104810	101,600	10,649	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.241807	3,491	844	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.109620	194,695	21,342	60.00
65.00	06500	RESPIRATORY THERAPY	0.215215	102,672	22,097	65.00
66.00	06600	PHYSICAL THERAPY	0.241602	8,882	2,146	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.212901	10,998	2,341	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.057425	69,369	3,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.254655	5,241	1,335	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200891	118,743	23,854	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.171288	0	0	76.01
76.03	03953	WOUND CARE	0.209391	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.467034	3,054	1,426	90.00
91.00	09100	EMERGENCY	0.143599	57,083	8,197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.529074	3,464	1,833	92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		798,404	128,229	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)		798,404		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Date/Time Prepared: 2/29/2016 1:35 pm

		Title XVIII	Hospital	PPS	
			before 1/1	on/after 1/1		
		0	1.00	1.01	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)		0			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,884,666			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)		0			2.00
2.01	Outlier reconciliation amount		0			2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0			2.02
3.00	Managed Care Simulated Payments		1,719,803			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		58.17			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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Date/Time Prepared: 2/29/2016 1:35 pm

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
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)		0.96			30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.72			31.00
32.00	Sum of lines 30 and 31		19.68			32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.54			33.00
34.00	Disproportionate share adjustment (see instructions)		53,803			34.00
			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0		7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000000000		0.000042511	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0		325,109	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0		325,109	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		325,109			36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0			46.00
47.00	Subtotal (see instructions)		4,263,578			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)		4,263,578			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		309,144			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		4,572,722			59.00
60.00	Primary payer payments		0			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		4,572,722			61.00
62.00	Deductibles billed to program beneficiaries		616,720			62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150075	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/29/2016 1:35 pm
	Title XVIII	Hospital	PPS

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
63.00	Coinsurance billed to program beneficiaries		5,040			63.00
64.00	Allowable bad debts (see instructions)		12,264			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		7,972			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		8,068			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		3,958,934			67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0			68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0			69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0			70.00
70.50	RURAL DEMONSTRATION PROJECT		0			70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0			70.91
70.92	Bundled Model 1 discount amount (see instructions)		0			70.92
70.93	HVBP payment adjustment amount (see instructions)		33,990			70.93
70.94	HRR adjustment amount (see instructions)		-76,528			70.94
70.95	Recovery of accelerated depreciation		0			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2015	342,954			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)		4,259,350			71.00
71.01	Sequestration adjustment (see instructions)		85,187			71.01
72.00	Interim payments		4,082,676			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)		91,487			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		918,832			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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150075	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/29/2016 1:35 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1		On/After 10/1	
		1.00	1.01	2.00	
	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)			0	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)			0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)			0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 2/29/2016 1:35 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,884,666	0	0	3,884,666	3,884,666	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,719,803	0	0	1,719,803	1,719,803	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0554	0.0554	0.0554	0.0554		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	53,803	0	0	53,803	53,803	11.00
11.01	Uncompensated care payments	36.00	325,109	0	0	325,109	325,109	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,263,578	0	0	4,263,578	4,263,578	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,263,578	0	0	4,263,578	4,263,578	15.00
16.00	Payment for inpatient program capital	50.00	309,144	0	0	309,144	309,144	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 2/29/2016 1:35 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	0	4,572,722	4,572,722	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	309,144	0	0	309,144	309,144	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	309,144	0	0	309,144	309,144	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.075000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				342,954	342,954	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part B Date/Time Prepared: 2/29/2016 1:35 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	114	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,961,682	2.00
3.00	PPS payments	2,583,200	3.00
4.00	Outlier payment (see instructions)	41,592	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)	114	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	568	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)	568	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)	568	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	454	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)	114	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	2,624,792	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	588	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	583,353	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,040,965	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)	2,040,965	30.00
31.00	Primary payer payments	454	31.00
32.00	Subtotal (line 30 minus line 31)	2,040,511	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)	50,797	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	33,018	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	49,664	36.00
37.00	Subtotal (see instructions)	2,073,529	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)	2,073,529	40.00
40.01	Sequestration adjustment (see instructions)	41,471	40.01
41.00	Interim payments	1,999,766	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	32,292	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: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/29/2016 1:35 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		4,082,676		1,999,766	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)		4,082,676		1,999,766	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		91,487		32,292	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,174,163		2,032,058	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: 150075 Component CCN: 155373	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part I Date/Time Prepared: 2/29/2016 1:35 pm
	Title XVIII	Skilled Nursing Facility	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		559,751		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		559,751		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		559,751		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150075	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 2/29/2016 1:35 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,638	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,695	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,159	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	5,852	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	153,994,994	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	282,762	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	346,032	8.00
9.00	Sequestration adjustment amount (see instructions)	6,921	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	339,111	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	339,111	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

	Provider CCN: 150075	Period: From 10/01/2014	Worksheet E-3 Part VI
	Component CCN: 155373	To 09/30/2015	Date/Time Prepared: 2/29/2016 1:35 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	612,892	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	612,892	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	41,717	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	571,175	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	571,175	15.00
15.01	Sequestration adjustment (see instructions)	11,424	15.01
16.00	Interim payments	559,751	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G | Date/Time Prepared: 2/29/2016 1:35 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	-183,866	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	5,986,966	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,376,613	0	0	0	6.00
7.00	Inventory	1,140,401	0	0	0	7.00
8.00	Prepaid expenses	292,213	0	0	0	8.00
9.00	Other current assets	410,826	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)	6,269,927	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,844,900	0	0	0	12.00
13.00	Land improvements	748,002	0	0	0	13.00
14.00	Accumulated depreciation	-370,204	0	0	0	14.00
15.00	Buildings	21,419,131	0	0	0	15.00
16.00	Accumulated depreciation	-8,632,283	0	0	0	16.00
17.00	Leasehold improvements	4,941,038	0	0	0	17.00
18.00	Accumulated depreciation	-3,132,292	0	0	0	18.00
19.00	Fixed equipment	4,217,516	0	0	0	19.00
20.00	Accumulated depreciation	-2,923,812	0	0	0	20.00
21.00	Automobiles and trucks	43,800	0	0	0	21.00
22.00	Accumulated depreciation	-43,800	0	0	0	22.00
23.00	Major movable equipment	10,425,758	0	0	0	23.00
24.00	Accumulated depreciation	-7,878,659	0	0	0	24.00
25.00	Minor equipment depreciable	2,817,295	0	0	0	25.00
26.00	Accumulated depreciation	-1,548,507	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)	23,927,883	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	3,618,262	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,618,262	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	33,816,072	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,219,788	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,289,421	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	26,147,793	0	0	0	43.00
44.00	Other current liabilities	164,527	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	28,821,529	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	28,821,529	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	4,994,543				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)	4,994,543	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	33,816,072	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-1 | Date/Time Prepared: 2/29/2016 1:35 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		6,161,896		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,167,351				2.00
3.00	Total (sum of line 1 and line 2)		4,994,545		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		4,994,545		0		11.00
12.00	ROUNDING	2		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)		2		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		4,994,543		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 150075 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/29/2016 1:35 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	10,143,198		10,143,198	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	2,612,744		2,612,744	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)	12,755,942		12,755,942	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,678,473		2,678,473	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)	2,678,473		2,678,473	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	15,434,415		15,434,415	17.00
18.00	Ancillary services	38,748,976	83,219,016	121,967,992	18.00
19.00	Outpatient services	3,199,162	13,393,425	16,592,587	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	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)	57,382,553	96,612,441	153,994,994	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,438,666		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)		38,438,666		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150075	Period: From 10/01/2014 To 09/30/2015	Worksheet G-3 Date/Time Prepared: 2/29/2016 1:35 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	153,994,994	1.00
2.00	Less contractual allowances and discounts on patients' accounts	117,509,031	2.00
3.00	Net patient revenues (line 1 minus line 2)	36,485,963	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,438,666	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,952,703	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 (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	0	25.00
26.00	Total (line 5 plus line 25)	-1,952,703	26.00
27.00	OTHER	-785,352	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-785,352	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,167,351	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150075	Period: From 10/01/2014 To 09/30/2015	Worksheet L Parts I-III Date/Time Prepared: 2/29/2016 1:35 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	309,144	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	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)	16.03	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)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	309,144	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