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: 150009	Period: From 01/01/2015 To 07/31/2015	Worksheet S Parts I-III Date/Time Prepared: 12/31/2015 9:40 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 12/31/2015 Time: 9:40 am
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 CLARK MEMORIAL HOSPITAL (150009) for the cost reporting period beginning 01/01/2015 and ending 07/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 12/31/2015 Time: 9:40 am
9ehyrfV1hU6Wem:iRV0DPsqZ0xoOF0
Jbk6b0vRaGTBAOmqi:qzJe82NC1uRY
fSR:0MsfKJ0HxiFC

PI: Date: 12/31/2015 Time: 9:40 am
ESs9rPywqIMgzoCh2fcZfJK2diVfL0
oEpkK0PoV0U.1VxUc4A4cF4no6XxOA
XVqq0m5i030bRla7

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

CFO
Title

12/31/15
Date

		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	179,507	-21,664	0	0	1.00
2.00	Subprovider - IPF	0	-25,049	1,764		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
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	154,458	-19,900	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 12/31/2015 9:20 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1220 MISSOURI AVENUE	PO Box: 69			1.00
2.00	City: JEFFERSONVILLE	State: IN	Zip Code: 47130	County: CLARK	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	CLARK MEMORIAL HOSPITAL	150009	31140	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF	BEHAVIORIAL MEDICINE UNIT	15S009	31140	4	01/01/1992	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2015	07/31/2015	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,249	1,231	492	176	1,450	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: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 12/31/2015 9:20 am

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 12/31/2015 9:20 am

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

	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 12/31/2015 9:20 am

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 12/31/2015 9:20 am

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 12/31/2015 9:20 am

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

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

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.25	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)	01/01/2015	07/31/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150009	Period: From 01/01/2015 To 07/31/2015	Worksheet S-2 Part I Date/Time Prepared: 12/31/2015 9:20 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 12/31/2015 9:20 am

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	10/07/2015	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 12/31/2015 9:20 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD	BKD	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD,LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502-581-0435	LVCOSTREPORTS@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 12/31/2015 9:20 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	10/07/2015			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.		BKD		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: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 12/31/2015 9:20 am

	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	135	28,620	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)		135	28,620	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	34	7,208	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)		169	35,828	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	20	4,240		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		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)		189				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: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 12/31/2015 9:20 am

	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)	9,162	1,682	21,012			1.00
2.00	HMO and other (see instructions)	2,925	3,349				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)	9,162	1,682	21,012			7.00
8.00	INTENSIVE CARE UNIT	2,778	429	5,360			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		138	1,724			13.00
14.00	Total (see instructions)	11,940	2,249	28,096	2.50	1,186.22	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,389	0	1,728	0.00	15.12	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	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)	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)				2.50	1,201.34	27.00
28.00	Observation Bed Days		0	2,251			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: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 12/31/2015 9:20 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,464	528	6,596	1.00
2.00	HMO and other (see instructions)			578	1,051		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,464	528	6,596	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	145	0	188	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 12/31/2015 9:20 am

		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	32,048,716	0	32,048,716	1,457,620.82	21.99	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)		101,337	0	101,337	3,462.25	29.27	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		507,162	-4,220	502,942	25,701.07	19.57	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		124,727	0	124,727	3,906.00	31.93	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		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,483,616	0	7,483,616			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		118,595	0	118,595			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	221,372	0	221,372	9,214.93	24.02	26.00
27.00	Administrative & General	5.00	4,736,881	0	4,736,881	202,329.19	23.41	27.00
28.00	Administrative & General under contract (see inst.)		327,562	0	327,562	2,438.34	134.34	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	624,518	0	624,518	32,990.13	18.93	30.00
31.00	Laundry & Linen Service	8.00	71,644	0	71,644	6,507.25	11.01	31.00
32.00	Housekeeping	9.00	882,236	0	882,236	72,595.51	12.15	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	788,092	0	788,092	65,141.74	12.10	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	253,943	0	253,943	8,143.16	31.18	38.00
39.00	Central Services and Supply	14.00	184,282	0	184,282	11,756.75	15.67	39.00
40.00	Pharmacy	15.00	1,555,124	0	1,555,124	45,750.15	33.99	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 12/31/2015 9:20 am

		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	785,751	0	785,751	43,996.66	17.86	41.00
42.00	Social Service	17.00	970,640	0	970,640	33,891.08	28.64	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet S-3 Part III Date/Time Prepared: 12/31/2015 9:20 am

		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)		32,274,941	0	32,274,941	1,456,596.91	22.16	1.00
2.00	Excluded area salaries (see instructions)		507,162	-4,220	502,942	25,701.07	19.57	2.00
3.00	Subtotal salaries (line 1 minus line 2)		31,767,779	4,220	31,771,999	1,430,895.84	22.20	3.00
4.00	Subtotal other wages & related costs (see inst.)		124,727	0	124,727	3,906.00	31.93	4.00
5.00	Subtotal wage-related costs (see inst.)		7,483,616	0	7,483,616	0.00	23.55	5.00
6.00	Total (sum of lines 3 thru 5)		39,376,122	4,220	39,380,342	1,434,801.84	27.45	6.00
7.00	Total overhead cost (see instructions)		11,402,045	0	11,402,045	534,754.89	21.32	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 12/31/2015 9:20 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	619,831	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)	4,106,659	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	117,064	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	-24,410	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)	99,793	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	164,327	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,377,025	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	8,954	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	132,968	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,602,211	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet S-3 Part V Date/Time Prepared: 12/31/2015 9:20 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	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	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150009	Period: From 01/01/2015 To 07/31/2015	Worksheet S-10 Date/Time Prepared: 12/31/2015 9:20 am

		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)	0.330578	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	15,808,339	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	35,193,421	6.00
7.00	Medicaid cost (line 1 times line 6)	11,634,171	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	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	2,373,183	1,553,455	3,926,638	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	784,522	513,538	1,298,060	21.00
22.00	Partial payment by patients approved for charity care	2,107	3,095	5,202	22.00
23.00	Cost of charity care (line 21 minus line 22)	782,415	510,443	1,292,858	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	14,856,000	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	303,875	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	14,552,125	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	4,810,612	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6,103,470	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,103,470	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet A | Date/Time Prepared: 12/31/2015 9:20 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		6,446,107	6,446,107	-3,090,172	3,355,935	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	4,701,243	4,701,243	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	221,372	7,700,763	7,922,135	-5,128	7,917,007	4.00
5.01	00540	NONPATIENT TELEPHONES	171,093	204,385	375,478	-15,628	359,850	5.01
5.02	00590	PURCHASING	346,605	385,973	732,578	-26,136	706,442	5.02
5.03	00570	ADMITTING	629,673	91,442	721,115	-13	721,102	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	508,211	535,817	1,044,028	0	1,044,028	5.04
5.05	00591	OTHER A&G	3,081,299	12,483,463	15,564,762	15,841	15,580,603	5.05
7.00	00700	OPERATION OF PLANT	624,518	3,505,415	4,129,933	40,519	4,170,452	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	71,644	480,418	552,062	0	552,062	8.00
9.00	00900	HOUSEKEEPING	882,236	194,168	1,076,404	-10,562	1,065,842	9.00
10.00	01000	DIETARY	788,092	1,008,968	1,797,060	-9,729	1,787,331	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	253,943	20,444	274,387	-6,957	267,430	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	184,282	108,947	293,229	1,715	294,944	14.00
15.00	01500	PHARMACY	1,555,124	4,166,078	5,721,202	0	5,721,202	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	785,751	417,760	1,203,511	-101,337	1,102,174	16.00
17.00	01700	SOCIAL SERVICE	970,640	183,194	1,153,834	0	1,153,834	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	101,337	101,337	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,082,343	679,595	6,761,938	-374,206	6,387,732	30.00
31.00	03100	INTENSIVE CARE UNIT	2,486,878	616,727	3,103,605	-448,300	2,655,305	31.00
40.00	04000	SUBPROVIDER - IPF	349,562	57,990	407,552	-17,302	390,250	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	387,501	45,863	433,364	-39,696	393,668	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,195,862	8,387,306	10,583,168	-6,376,083	4,207,085	50.00
51.00	05100	RECOVERY ROOM	490,078	125,063	615,141	-113,638	501,503	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	597,878	192,857	790,735	-115,773	674,962	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,318,036	1,769,152	4,087,188	-1,011,533	3,075,655	54.00
59.00	05900	CARDIAC CATHETERIZATION	526,274	1,750,459	2,276,733	-1,669,677	607,056	59.00
60.00	06000	LABORATORY	1,516,884	2,331,094	3,847,978	-13,751	3,834,227	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	632,961	632,961	-586,855	46,106	63.00
64.00	06400	INTRAVENOUS THERAPY	115,929	204,397	320,326	0	320,326	64.00
65.00	06500	RESPIRATORY THERAPY	941,057	656,005	1,597,062	-92,729	1,504,333	65.00
66.00	06600	PHYSICAL THERAPY	487,341	16,000	503,341	-13,064	490,277	66.00
69.00	06900	ELECTROCARDIOLOGY	305,208	32,181	337,389	-17,010	320,379	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	33,615	31,800	65,415	-1,400	64,015	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,302,350	7,302,350	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,154,068	4,154,068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	261,361	261,361	0	261,361	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	63,425	4,222	67,647	0	67,647	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,918,762	814,478	2,733,240	-491,986	2,241,254	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,700,919	1,700,919	-1,628,994	71,925	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,891,116	58,243,772	90,134,888	39,414	90,174,302	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	SIRH	131,862	68,848	200,710	-34,878	165,832	194.00
194.01	07951	OTHER NRCC	25,738	346,091	371,829	-4,536	367,293	194.01
200.00		TOTAL (SUM OF LINES 118-199)	32,048,716	58,658,711	90,707,427	0	90,707,427	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet A | Date/Time Prepared: 12/31/2015 9:20 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-178,146	3,177,789		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-30,829	4,670,414		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-12,861	7,904,146		4.00
5.01	00540	NONPATIENT TELEPHONES	0	359,850		5.01
5.02	00590	PURCHASING	5,710	712,152		5.02
5.03	00570	ADMITTING	0	721,102		5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,044,028		5.04
5.05	00591	OTHER A&G	-1,256,405	14,324,198		5.05
7.00	00700	OPERATION OF PLANT	-177,548	3,992,904		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	552,062		8.00
9.00	00900	HOUSEKEEPING	0	1,065,842		9.00
10.00	01000	DIETARY	-551,612	1,235,719		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	267,430		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	294,944		14.00
15.00	01500	PHARMACY	0	5,721,202		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-51,354	1,050,820		16.00
17.00	01700	SOCIAL SERVICE	0	1,153,834		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	101,337		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-7,164	6,380,568		30.00
31.00	03100	INTENSIVE CARE UNIT	-20,781	2,634,524		31.00
40.00	04000	SUBPROVIDER - IPF	-30,000	360,250		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	393,668		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-830,775	3,376,310		50.00
51.00	05100	RECOVERY ROOM	0	501,503		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-33,750	641,212		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,075,655		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	607,056		59.00
60.00	06000	LABORATORY	-46,667	3,787,560		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	46,106		63.00
64.00	06400	INTRAVENOUS THERAPY	0	320,326		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,504,333		65.00
66.00	06600	PHYSICAL THERAPY	0	490,277		66.00
69.00	06900	ELECTROCARDIOLOGY	-4,200	316,179		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	64,015		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,302,350		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,154,068		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	261,361		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	67,647		76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-8,860	2,232,394		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-71,925	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,307,167	86,867,135		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	SIRH	0	165,832		194.00
194.01	07951	OTHER NRCC	0	367,293		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-3,307,167	87,400,260		200.00

RECLASSIFICATIONS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet A-6 | Date/Time Prepared: 12/31/2015 9:20 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTERNS AND RESIDENTS RECLASS					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	101,337		1.00
	0		0	101,337		
	B - NEW DIRECTIONS ADMIN RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	4,220	450		1.00
	0		4,220	450		
	C - INTEREST EXPENSE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,514,723		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27,257		2.00
3.00	OTHER A&G	5.05	0	87,014		3.00
	0		0	1,628,994		
	D - DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	4,673,986		1.00
	0		0	4,673,986		
	E - INURANCE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	69,091		1.00
	0		0	69,091		
	F - UTILITIES EXPENSE RECLASS					
1.00	NONPATIENT TELEPHONES	5.01	0	7,214		1.00
2.00	OPERATION OF PLANT	7.00	0	47,380		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
	0		0	54,594		
	G - CHARGEABLE SUPPLIES RECLASS					
1.00		0.00	0	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,715		2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	11,456,418		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
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
	0		0	11,458,133		
	H - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	4,154,068		1.00
	0		0	4,154,068		
	I - MAINTENANCE RECLASS					
1.00	OPERATION OF PLANT	7.00	0	4,505		1.00
	0		0	4,505		
500.00	Grand Total: Increases		4,220	22,145,158		500.00

RECLASSIFICATIONS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet A-6 | Date/Time Prepared: 12/31/2015 9:20 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTERNS AND RESIDENTS RECLASS						
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	101,337	0		1.00
	0		0	101,337			
	B - NEW DIRECTIONS ADMIN RECLASS						
1.00	SUBPROVIDER - IPF	40.00	4,220	450	0		1.00
	0		4,220	450			
	C - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	1,628,994	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	0		3.00
	0		0	1,628,994			
	D - DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	4,673,986	9		1.00
	0		0	4,673,986			
	E - INURANCE RECLASS						
1.00	OTHER A&G	5.05	0	69,091	12		1.00
	0		0	69,091			
	F - UTILITIES EXPENSE RECLASS						
1.00	NONPATIENT TELEPHONES	5.01	0	22,842	0		1.00
2.00	OTHER A&G	5.05	0	1,552	0		2.00
3.00	OPERATION OF PLANT	7.00	0	214	0		3.00
4.00	OPERATING ROOM	50.00	0	543	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,443	0		5.00
	0		0	54,594			
	G - CHARGEABLE SUPPLIES RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,128	0		1.00
2.00	PURCHASING	5.02	0	26,136	0		2.00
3.00	ADMITTING	5.03	0	13	0		3.00
4.00	OTHER A&G	5.05	0	530	0		4.00
5.00	OPERATION OF PLANT	7.00	0	11,152	0		5.00
6.00	HOUSEKEEPING	9.00	0	10,562	0		6.00
7.00	DIETARY	10.00	0	9,729	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	6,957	0		8.00
10.00	ADULTS & PEDIATRICS	30.00	0	378,876	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	448,300	0		11.00
12.00	SUBPROVIDER - IPF	40.00	0	12,632	0		12.00
13.00	NURSERY	43.00	0	39,696	0		13.00
14.00	OPERATING ROOM	50.00	0	6,375,540	0		14.00
15.00	RECOVERY ROOM	51.00	0	113,638	0		15.00
16.00	DELIVERY ROOM & LABOR ROOM	52.00	0	115,773	0		16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	982,090	0		17.00
18.00	CARDIAC CATHETERIZATION	59.00	0	1,669,677	0		18.00
19.00	LABORATORY	60.00	0	13,751	0		19.00
20.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	586,855	0		20.00
21.00	RESPIRATORY THERAPY	65.00	0	92,729	0		21.00
22.00	PHYSICAL THERAPY	66.00	0	13,064	0		22.00
23.00	ELECTROCARDIOLOGY	69.00	0	17,010	0		23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,400	0		24.00
26.00	EMERGENCY	91.00	0	491,986	0		26.00
27.00	SIRH	194.00	0	34,878	0		27.00
28.00	OTHER NRCC	194.01	0	31	0		28.00
	0		0	11,458,133			
	H - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,154,068	0		1.00
	0		0	4,154,068			
	I - MAINTENANCE RECLASS						
1.00	OTHER NRCC	194.01	0	4,505	0		1.00
	0		0	4,505			
500.00	Grand Total: Decreases		4,220	22,145,158			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 12/31/2015 9:20 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,071,554	0	0	0	125,611	1.00
2.00	Land Improvements	1,458,980	0	0	0	0	2.00
3.00	Buildings and Fixtures	87,028,220	128,920	0	128,920	0	3.00
4.00	Building Improvements	1,571,996	535,695	0	535,695	0	4.00
5.00	Fixed Equipment	20,622,577	609,598	0	609,598	0	5.00
6.00	Movable Equipment	111,753,953	1,073,101	0	1,073,101	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	228,507,280	2,347,314	0	2,347,314	125,611	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	228,507,280	2,347,314	0	2,347,314	125,611	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	5,945,943	0	1.00
2.00	Land Improvements	1,458,980	0	2.00
3.00	Buildings and Fixtures	87,157,140	0	3.00
4.00	Building Improvements	2,107,691	0	4.00
5.00	Fixed Equipment	21,232,175	0	5.00
6.00	Movable Equipment	112,827,054	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	230,728,983	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	230,728,983	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 12/31/2015 9:20 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	6,438,619	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,438,619	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	7,488	6,446,107	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	7,488	6,446,107	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 12/31/2015 9:20 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	117,901,929	0	117,901,929	0.510997	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	112,827,054	0	112,827,054	0.489003	0	2.00
3.00	Total (sum of lines 1-2)	230,728,983	0	230,728,983	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,593,975	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	4,643,157	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,237,132	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,514,723	69,091	0	0	3,177,789	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	27,257	0	0	0	4,670,414	2.00
3.00	Total (sum of lines 1-2)	1,541,980	69,091	0	0	7,848,203	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet A-8 | Date/Time Prepared: 12/31/2015 9:20 am

	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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW 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)	B	-255,364	OTHER A&G	5.05	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	-7,104	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	7.00
8.00	Television and radio service (chapter 21)	A	-3,706	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-990,105			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-534,264	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-36,282	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-17,348	DIETARY	10.00	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet A-8 | Date/Time Prepared: 12/31/2015 9:20 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	AHA DUES - LOBBYING PORTION	A	-3,952	OTHER A&G	5.05	0	33.00
34.00	NONALLOWABLE DEPRECIATION - BUILDING	A	-170,658	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
35.00	NONALLOWABLE DEPRECIATION - EQUIP	A	-20,019	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	35.00
36.00	UTILITIES	A	-177,548	OPERATION OF PLANT	7.00	0	36.00
37.00	TAXI EXPENSE	A	-2,756	OTHER A&G	5.05	0	37.00
38.00	ADVERTISING - PERSONNEL	A	-12,861	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	ADVERTISING - A & G	A	-602,186	OTHER A&G	5.05	0	39.00
40.00	ADVERTISING - A&P	A	-7,164	ADULTS & PEDIATRICS	30.00	0	40.00
41.00	GOODWILL AMORTIZATION	A	-7,488	NEW CAP REL COSTS-BLDG & FIXT	1.00	14	41.00
42.00	PHYSICIAN RECRUITMENT	A	-6,464	OTHER A&G	5.05	0	42.00
43.00	DONATIONS	A	-101,706	OTHER A&G	5.05	0	43.00
44.00	INTEREST INCOME	B	-71,925	INTEREST EXPENSE	113.00	0	44.00
45.00	RENTAL INCOME	B	-14,642	OTHER A&G	5.05	0	45.00
46.00	MISCELLANEOUS INCOME - A & G	B	-256,843	OTHER A&G	5.05	0	46.00
47.00	REBATES - MATERIAL MGMT	B	5,710	PURCHASING	5.02	0	47.00
48.00	CABLE TELEVISION	A	-12,492	OTHER A&G	5.05	0	48.00
49.00			0		0.00	0	49.00
49.01			0		0.00	0	49.01
49.02			0		0.00	0	49.02
49.03			0		0.00	0	49.03
49.04			0		0.00	0	49.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,307,167				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 12/31/2015 9:20 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	16.00	MEDICAL RECORDS & LIBRARY	15,072	15,072	0	177,200	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	20,781	20,781	0	177,200	0	2.00
3.00	40.00	SUBPROVIDER - IPF	30,000	30,000	0	154,100	0	3.00
4.00	50.00	OPERATING ROOM	830,775	830,775	0	208,000	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	33,750	33,750	0	196,400	0	5.00
6.00	60.00	LABORATORY	46,667	46,667	0	215,700	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	4,200	4,200	0	225,300	0	7.00
8.00	91.00	EMERGENCY	8,860	8,860	0	177,200	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			990,105	990,105	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	16.00	MEDICAL RECORDS & LIBRARY	0	0	0	15,072		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	20,781		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	30,000		3.00
4.00	50.00	OPERATING ROOM	0	0	0	830,775		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	33,750		5.00
6.00	60.00	LABORATORY	0	0	0	46,667		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	4,200		7.00
8.00	91.00	EMERGENCY	0	0	0	8,860		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	990,105		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet B Part I Date/Time Prepared: 12/31/2015 9:20 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	3,177,789	3,177,789				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	4,670,414		4,670,414			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,904,146	0	0	7,904,146		4.00
5.01	00540	NONPATIENT TELEPHONES	359,850	0	0	42,490	402,340	5.01
5.02	00590	PURCHASING	712,152	16,549	24,322	86,078	5,928	5.02
5.03	00570	ADMITTING	721,102	122,105	179,459	156,376	5,533	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,044,028	180,570	265,384	126,212	18,180	5.04
5.05	00591	OTHER A&G	14,324,198	293,463	431,304	765,225	116,197	5.05
7.00	00700	OPERATION OF PLANT	3,992,904	488,621	718,129	155,096	11,066	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552,062	0	0	17,792	790	8.00
9.00	00900	HOUSEKEEPING	1,065,842	0	0	219,099	0	9.00
10.00	01000	DIETARY	1,235,719	153,536	225,652	195,719	6,719	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	267,430	26,263	38,600	63,065	1,976	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	294,944	50,852	74,737	45,766	3,162	14.00
15.00	01500	PHARMACY	5,721,202	31,355	46,083	386,207	5,533	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,050,820	0	0	195,137	18,180	16.00
17.00	01700	SOCIAL SERVICE	1,153,834	0	0	241,054	6,719	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	101,337	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,380,568	637,911	937,542	1,511,551	32,409	30.00
31.00	03100	INTENSIVE CARE UNIT	2,634,524	61,731	90,726	617,604	10,671	31.00
40.00	04000	SUBPROVIDER - IPF	360,250	136,878	201,171	85,764	3,952	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	393,668	0	0	96,234	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,376,310	234,839	345,144	545,331	27,666	50.00
51.00	05100	RECOVERY ROOM	501,503	0	0	121,708	5,533	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	641,212	127,909	187,988	148,480	5,533	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,075,655	233,147	342,657	575,673	19,761	54.00
59.00	05900	CARDIAC CATHETERIZATION	607,056	53,599	78,775	130,698	8,300	59.00
60.00	06000	LABORATORY	3,787,560	95,875	140,908	376,711	14,228	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	46,106	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	320,326	0	0	28,790	1,186	64.00
65.00	06500	RESPIRATORY THERAPY	1,504,333	0	0	233,707	0	65.00
66.00	06600	PHYSICAL THERAPY	490,277	0	0	121,029	2,767	66.00
69.00	06900	ELECTROCARDIOLOGY	316,179	31,757	46,674	75,797	4,743	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	64,015	5,159	7,582	8,348	1,976	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,302,350	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,154,068	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	261,361	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	67,647	0	0	15,751	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,232,394	169,842	249,617	476,515	20,157	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	86,867,135	3,151,961	4,632,454	7,865,007	358,865	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,834	10,044	0	1,581	190.00
194.00	07950	SIRH	165,832	0	0	32,747	0	194.00
194.01	07951	OTHER NRCC	367,293	18,994	27,916	6,392	41,894	194.01
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)	87,400,260	3,177,789	4,670,414	7,904,146	402,340	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet B Part I | Date/Time Prepared: 12/31/2015 9:20 am

		Cost Center Description	PURCHASING	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER A&G	
			5.02	5.03	5.04	5A.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	PURCHASING	845,029					5.02
5.03	00570	ADMITTING	5,017	1,189,592				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	1,634,374			5.04
5.05	00591	OTHER A&G	924	0	0	15,931,311	15,931,311	5.05
7.00	00700	OPERATION OF PLANT	338	0	0	5,366,154	1,196,180	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,908	0	0	574,552	128,075	8.00
9.00	00900	HOUSEKEEPING	26,595	0	0	1,311,536	292,357	9.00
10.00	01000	DIETARY	8,568	0	0	1,825,913	407,018	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	93	0	0	397,427	88,591	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	469,461	104,648	14.00
15.00	01500	PHARMACY	23,502	0	0	6,213,882	1,385,149	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	60	0	0	1,264,197	281,805	16.00
17.00	01700	SOCIAL SERVICE	12	0	0	1,401,619	312,438	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	101,337	22,589	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,386	62,105	85,339	9,693,811	2,160,890	30.00
31.00	03100	INTENSIVE CARE UNIT	44,101	23,260	31,961	3,514,578	783,442	31.00
40.00	04000	SUBPROVIDER - IPF	2,049	4,543	6,243	800,850	178,519	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	2,094	3,007	4,132	499,135	111,263	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,023	98,508	135,359	4,801,180	1,070,241	50.00
51.00	05100	RECOVERY ROOM	3,153	15,156	20,826	667,879	148,878	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,836	5,847	8,034	1,139,839	254,084	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,658	249,257	342,264	4,856,072	1,082,477	54.00
59.00	05900	CARDIAC CATHETERIZATION	4,087	40,283	55,353	978,151	218,042	59.00
60.00	06000	LABORATORY	541,532	129,754	178,295	5,264,863	1,173,601	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	21,738	51,063	70,165	189,072	42,146	63.00
64.00	06400	INTRAVENOUS THERAPY	4,612	34,349	47,199	436,462	97,293	64.00
65.00	06500	RESPIRATORY THERAPY	2,037	62,531	85,923	1,888,531	420,976	65.00
66.00	06600	PHYSICAL THERAPY	386	8,753	12,028	635,240	141,603	66.00
69.00	06900	ELECTROCARDIOLOGY	1,538	31,114	42,753	550,555	122,725	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	126	5,232	7,189	99,627	22,208	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	151,125	207,660	7,661,135	1,707,759	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	52,512	72,156	4,278,736	953,782	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	92,735	127,427	220,162	49,077	73.00
74.00	07400	RENAL DIALYSIS	0	1,310	1,800	264,471	58,954	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	19	1,554	2,136	87,107	19,417	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	30,946	65,594	90,132	3,335,197	743,455	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	844,338	1,189,592	1,634,374	86,720,042	15,779,682	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	18,459	4,115	190.00
194.00	07950	SIRH	643	0	0	199,222	44,409	194.00
194.01	07951	OTHER NRCC	48	0	0	462,537	103,105	194.01
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)	845,029	1,189,592	1,634,374	87,400,260	15,931,311	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet B Part I Date/Time Prepared: 12/31/2015 9:20 am

		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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	PURCHASING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00591	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT	6,562,334					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	702,627				8.00
9.00	00900	HOUSEKEEPING	0	0	1,603,893			9.00
10.00	01000	DIETARY	485,221	0	3,730	2,721,882		10.00
11.00	01100	CAFETERIA	0	0	0	2,054,347	2,054,347	11.00
13.00	01300	NURSING ADMINISTRATION	83,001	0	0	0	15,651	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	160,708	0	14,298	0	0	14.00
15.00	01500	PHARMACY	99,093	0	4,973	0	110,530	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	3,108	0	84,564	16.00
17.00	01700	SOCIAL SERVICE	0	0	622	0	65,140	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,016,002	403,638	833,030	576,115	577,223	30.00
31.00	03100	INTENSIVE CARE UNIT	195,089	126,348	231,881	74,578	220,745	31.00
40.00	04000	SUBPROVIDER - IPF	432,578	120,363	92,628	7,133	35,260	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	40,616	622	0	26,709	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	742,164	0	62,166	0	165,527	50.00
51.00	05100	RECOVERY ROOM	0	4,500	0	1,783	37,779	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	404,232	3,581	92,628	1,101	49,177	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	736,818	0	42,273	0	179,043	54.00
59.00	05900	CARDIAC CATHETERIZATION	169,389	165	18,028	0	32,404	59.00
60.00	06000	LABORATORY	302,995	0	29,218	0	133,214	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	622	0	7,021	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	622	0	77,410	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,243	0	26,776	66.00
69.00	06900	ELECTROCARDIOLOGY	100,363	0	3,108	0	23,209	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16,304	0	622	0	2,695	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	0	1,243	0	7,023	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	536,753	3,416	167,228	6,825	163,109	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,480,710	702,627	1,603,893	2,721,882	2,040,209	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,597	0	0	0	0	190.00
194.00	07950	SIRH	0	0	0	0	11,044	194.00
194.01	07951	OTHER NRCC	60,027	0	0	0	3,094	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,562,334	702,627	1,603,893	2,721,882	2,054,347	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet B Part I Date/Time Prepared: 12/31/2015 9:20 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	16A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	PURCHASING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00591	OTHER A&G						5.05
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	584,670					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,878	758,993				14.00
15.00	01500	PHARMACY	0	0	7,813,627			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,633,674		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1,779,819	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	123,926	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	252,316	0	0	147,721	16,660,746	30.00
31.00	03100	INTENSIVE CARE UNIT	96,492	0	0	27,562	5,270,715	31.00
40.00	04000	SUBPROVIDER - IPF	15,413	0	0	7,686	1,690,430	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	11,675	0	0	59,470	749,490	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	72,355	0	0	174,435	7,088,068	50.00
51.00	05100	RECOVERY ROOM	16,514	0	0	0	877,333	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,496	0	0	4,558	1,970,696	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	666,411	7,563,094	54.00
59.00	05900	CARDIAC CATHETERIZATION	14,164	0	0	25,654	1,455,997	59.00
60.00	06000	LABORATORY	0	0	0	40,336	6,944,227	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	231,218	63.00
64.00	06400	INTRAVENOUS THERAPY	3,069	0	0	0	544,467	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	2,387,539	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	804,862	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	799,960	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	141,456	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	485,756	0	0	9,854,650	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	273,237	0	0	5,505,755	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,813,627	0	8,082,866	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	323,425	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	0	0	0	114,790	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	71,298	0	0	479,841	5,507,122	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	584,670	758,993	7,813,627	1,633,674	86,472,651	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	44,171	190.00
194.00	07950	SIRH	0	0	0	0	254,675	194.00
194.01	07951	OTHER NRCC	0	0	0	0	628,763	194.01
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)	584,670	758,993	7,813,627	1,633,674	87,400,260	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet B Part I Date/Time Prepared: 12/31/2015 9:20 am

		Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			17.00	21.00	22.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	PURCHASING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00591	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	1,779,819					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,576		126,502			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	346,352	0	126,502	17,133,600	-126,502	30.00
31.00	03100	INTENSIVE CARE UNIT	109,562	0	0	5,380,277	0	31.00
40.00	04000	SUBPROVIDER - IPF	35,139	0	0	1,725,569	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	15,580	0	0	765,070	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	147,340	0	0	7,235,408	0	50.00
51.00	05100	RECOVERY ROOM	18,237	0	0	895,570	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	40,965	0	0	2,011,661	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	157,214	0	0	7,720,308	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	30,266	0	0	1,486,263	0	59.00
60.00	06000	LABORATORY	144,350	0	0	7,088,577	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,806	0	0	236,024	0	63.00
64.00	06400	INTRAVENOUS THERAPY	11,318	0	0	555,785	0	64.00
65.00	06500	RESPIRATORY THERAPY	49,630	0	0	2,437,169	0	65.00
66.00	06600	PHYSICAL THERAPY	16,731	0	0	821,593	0	66.00
69.00	06900	ELECTROCARDIOLOGY	16,629	0	0	816,589	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,940	0	0	144,396	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	204,849	0	0	10,059,499	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	114,448	0	0	5,620,203	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	168,019	0	0	8,250,885	0	73.00
74.00	07400	RENAL DIALYSIS	6,723	0	0	330,148	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	2,386	0	0	117,176	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	114,477	0	0	5,621,599	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,760,537	0	126,502	86,453,369	-126,502	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	918	0	0	45,089	0	190.00
194.00	07950	SIRH	5,294	0	0	259,969	0	194.00
194.01	07951	OTHER NRCC	13,070	0	0	641,833	0	194.01
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,779,819	0	126,502	87,400,260	-126,502	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet B Part I | Date/Time Prepared: 12/31/2015 9:20 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00590	PURCHASING			5.02
5.03	00570	ADMITTING			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05	00591	OTHER A&G			5.05
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	17,007,098		30.00
31.00	03100	INTENSIVE CARE UNIT	5,380,277		31.00
40.00	04000	SUBPROVIDER - IPF	1,725,569		40.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
42.00	04200	SUBPROVIDER	0		42.00
43.00	04300	NURSERY	765,070		43.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	7,235,408		50.00
51.00	05100	RECOVERY ROOM	895,570		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,011,661		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,720,308		54.00
59.00	05900	CARDIAC CATHETERIZATION	1,486,263		59.00
60.00	06000	LABORATORY	7,088,577		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	236,024		63.00
64.00	06400	INTRAVENOUS THERAPY	555,785		64.00
65.00	06500	RESPIRATORY THERAPY	2,437,169		65.00
66.00	06600	PHYSICAL THERAPY	821,593		66.00
69.00	06900	ELECTROCARDIOLOGY	816,589		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	144,396		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,059,499		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,620,203		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,250,885		73.00
74.00	07400	RENAL DIALYSIS	330,148		74.00
76.00	03950	ANCILLARY	0		76.00
76.01	03951	PARTIAL HOSPITALIZATION	117,176		76.01
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	5,621,599		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	86,326,867		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	45,089		190.00
194.00	07950	SIRH	259,969		194.00
194.01	07951	OTHER NRCC	641,833		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	87,273,758		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet B Part II Date/Time Prepared: 12/31/2015 9:20 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00590	PURCHASING	0	16,549	24,322	40,871	0	5.02
5.03	00570	ADMITTING	0	122,105	179,459	301,564	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	180,570	265,384	445,954	0	5.04
5.05	00591	OTHER A&G	0	293,463	431,304	724,767	0	5.05
7.00	00700	OPERATION OF PLANT	0	488,621	718,129	1,206,750	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	153,536	225,652	379,188	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	26,263	38,600	64,863	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	50,852	74,737	125,589	0	14.00
15.00	01500	PHARMACY	0	31,355	46,083	77,438	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	637,911	937,542	1,575,453	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	61,731	90,726	152,457	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	136,878	201,171	338,049	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	234,839	345,144	579,983	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	127,909	187,988	315,897	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	233,147	342,657	575,804	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	53,599	78,775	132,374	0	59.00
60.00	06000	LABORATORY	0	95,875	140,908	236,783	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	31,757	46,674	78,431	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,159	7,582	12,741	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	169,842	249,617	419,459	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,151,961	4,632,454	7,784,415	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,834	10,044	16,878	0	190.00
194.00	07950	SIRH	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	18,994	27,916	46,910	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	3,177,789	4,670,414	7,848,203	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet B Part II | Date/Time Prepared: 12/31/2015 9:20 am

		Cost Center Description	NONPATIENT TELEPHONES	PURCHASING	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER A&G	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	0					5.01
5.02	00590	PURCHASING	0	40,871				5.02
5.03	00570	ADMITTING	0	243	301,807			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	445,954		5.04
5.05	00591	OTHER A&G	0	45	0	0	724,812	5.05
7.00	00700	OPERATION OF PLANT	0	16	0	0	54,424	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	189	0	0	5,827	8.00
9.00	00900	HOUSEKEEPING	0	1,286	0	0	13,302	9.00
10.00	01000	DIETARY	0	414	0	0	18,518	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5	0	0	4,031	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	4,761	14.00
15.00	01500	PHARMACY	0	1,137	0	0	63,021	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3	0	0	12,821	16.00
17.00	01700	SOCIAL SERVICE	0	1	0	0	14,215	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	1,028	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,243	15,762	23,288	98,289	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,133	5,903	8,722	35,645	31.00
40.00	04000	SUBPROVIDER - IPF	0	99	1,153	1,704	8,122	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	101	763	1,128	5,062	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,839	25,000	36,938	48,694	50.00
51.00	05100	RECOVERY ROOM	0	153	3,846	5,683	6,774	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	718	1,484	2,192	11,560	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	854	63,164	93,354	49,250	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	198	10,223	15,105	9,920	59.00
60.00	06000	LABORATORY	0	26,191	32,930	48,654	53,396	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,051	12,959	19,147	1,918	63.00
64.00	06400	INTRAVENOUS THERAPY	0	223	8,717	12,880	4,427	64.00
65.00	06500	RESPIRATORY THERAPY	0	99	15,869	23,447	19,153	65.00
66.00	06600	PHYSICAL THERAPY	0	19	2,221	3,282	6,443	66.00
69.00	06900	ELECTROCARDIOLOGY	0	74	7,896	11,667	5,584	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6	1,328	1,962	1,010	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	38,354	56,668	77,699	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	13,327	19,690	43,395	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	23,535	34,773	2,233	73.00
74.00	07400	RENAL DIALYSIS	0	0	332	491	2,682	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	1	394	583	883	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	1,497	16,647	24,596	33,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	40,838	301,807	445,954	717,913	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	187	190.00
194.00	07950	SIRH	0	31	0	0	2,021	194.00
194.01	07951	OTHER NRCC	0	2	0	0	4,691	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	40,871	301,807	445,954	724,812	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet B Part II | Date/Time Prepared: 12/31/2015 9:20 am

		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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	PURCHASING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00591	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT	1,261,190					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,016				8.00
9.00	00900	HOUSEKEEPING	0	0	14,588			9.00
10.00	01000	DIETARY	93,253	0	34	491,407		10.00
11.00	01100	CAFETERIA	0	0	0	370,891	370,891	11.00
13.00	01300	NURSING ADMINISTRATION	15,952	0	0	0	2,826	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	30,886	0	130	0	0	14.00
15.00	01500	PHARMACY	19,044	0	45	0	19,955	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	28	0	15,267	16.00
17.00	01700	SOCIAL SERVICE	0	0	6	0	11,760	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	387,447	3,455	7,578	104,011	104,212	30.00
31.00	03100	INTENSIVE CARE UNIT	37,493	1,082	2,109	13,464	39,853	31.00
40.00	04000	SUBPROVIDER - IPF	83,136	1,031	842	1,288	6,366	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	348	6	0	4,822	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	142,634	0	565	0	29,884	50.00
51.00	05100	RECOVERY ROOM	0	39	0	322	6,821	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	77,688	31	842	199	8,878	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	141,606	0	384	0	32,324	54.00
59.00	05900	CARDIAC CATHETERIZATION	32,554	1	164	0	5,850	59.00
60.00	06000	LABORATORY	58,232	0	266	0	24,050	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	6	0	1,268	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	6	0	13,976	65.00
66.00	06600	PHYSICAL THERAPY	0	0	11	0	4,834	66.00
69.00	06900	ELECTROCARDIOLOGY	19,288	0	28	0	4,190	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,133	0	6	0	486	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	0	11	0	1,268	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	103,157	29	1,521	1,232	29,448	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,245,503	6,016	14,588	491,407	368,338	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,151	0	0	0	0	190.00
194.00	07950	SIRH	0	0	0	0	1,994	194.00
194.01	07951	OTHER NRCC	11,536	0	0	0	559	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,261,190	6,016	14,588	491,407	370,891	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet B Part II | Date/Time Prepared: 12/31/2015 9:20 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	PURCHASING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00591	OTHER A&G						5.05
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	87,677					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,481	162,847				14.00
15.00	01500	PHARMACY	0	0	180,640			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	28,119		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	25,982	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	38	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,838	0	0	2,543	5,087	30.00
31.00	03100	INTENSIVE CARE UNIT	14,470	0	0	474	1,597	31.00
40.00	04000	SUBPROVIDER - IPF	2,311	0	0	132	512	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	1,751	0	0	1,024	227	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,850	0	0	3,002	2,148	50.00
51.00	05100	RECOVERY ROOM	2,476	0	0	0	266	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,224	0	0	78	597	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,471	2,292	54.00
59.00	05900	CARDIAC CATHETERIZATION	2,124	0	0	442	441	59.00
60.00	06000	LABORATORY	0	0	0	694	2,104	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	70	63.00
64.00	06400	INTRAVENOUS THERAPY	460	0	0	0	165	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	723	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	244	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	242	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	43	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	104,222	0	0	2,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	58,625	0	0	1,668	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	180,640	0	2,449	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	98	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	0	0	0	35	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,692	0	0	8,259	1,669	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	87,677	162,847	180,640	28,119	25,701	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	13	190.00
194.00	07950	SIRH	0	0	0	0	77	194.00
194.01	07951	OTHER NRCC	0	0	0	0	191	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	87,677	162,847	180,640	28,119	25,982	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet B Part II Date/Time Prepared: 12/31/2015 9:20 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			21.00	22.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	PURCHASING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00591	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		1,066				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS			2,367,206	0	2,367,206	30.00
31.00	03100	INTENSIVE CARE UNIT			315,402	0	315,402	31.00
40.00	04000	SUBPROVIDER - IPF			444,745	0	444,745	40.00
41.00	04100	SUBPROVIDER - IRF			0	0	0	41.00
42.00	04200	SUBPROVIDER			0	0	0	42.00
43.00	04300	NURSERY			15,232	0	15,232	43.00
44.00	04400	SKILLED NURSING FACILITY			0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM			881,537	0	881,537	50.00
51.00	05100	RECOVERY ROOM			26,380	0	26,380	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			423,388	0	423,388	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			970,503	0	970,503	54.00
59.00	05900	CARDIAC CATHETERIZATION			209,396	0	209,396	59.00
60.00	06000	LABORATORY			483,300	0	483,300	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.			35,145	0	35,145	63.00
64.00	06400	INTRAVENOUS THERAPY			28,146	0	28,146	64.00
65.00	06500	RESPIRATORY THERAPY			73,273	0	73,273	65.00
66.00	06600	PHYSICAL THERAPY			17,054	0	17,054	66.00
69.00	06900	ELECTROCARDIOLOGY			127,400	0	127,400	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY			20,715	0	20,715	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS			279,929	0	279,929	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT			136,705	0	136,705	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			243,630	0	243,630	73.00
74.00	07400	RENAL DIALYSIS			3,603	0	3,603	74.00
76.00	03950	ANCILLARY			0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION			3,175	0	3,175	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY			652,032	0	652,032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	7,757,896	0	7,757,896	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN			21,229	0	21,229	190.00
194.00	07950	SIRH			4,123	0	4,123	194.00
194.01	07951	OTHER NRCC			63,889	0	63,889	194.01
200.00		Cross Foot Adjustments	0	1,066	1,066	0	1,066	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,066	7,848,203	0	7,848,203	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet B-1 | Date/Time Prepared: 12/31/2015 9:20 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONES)	PURCHASING (SUPPLIES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	379,445					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		379,445				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	31,827,344			4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	171,093	1,018		5.01
5.02	00590	PURCHASING	1,976	1,976	346,605	15	1,730,479	5.02
5.03	00570	ADMITTING	14,580	14,580	629,673	14	10,273	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	21,561	21,561	508,211	46	0	5.04
5.05	00591	OTHER A&G	35,041	35,041	3,081,299	294	1,892	5.05
7.00	00700	OPERATION OF PLANT	58,344	58,344	624,518	28	692	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	71,644	2	8,002	8.00
9.00	00900	HOUSEKEEPING	0	0	882,236	0	54,462	9.00
10.00	01000	DIETARY	18,333	18,333	788,092	17	17,546	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,136	3,136	253,943	5	191	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,072	6,072	184,282	8	0	14.00
15.00	01500	PHARMACY	3,744	3,744	1,555,124	14	48,128	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	785,751	46	123	16.00
17.00	01700	SOCIAL SERVICE	0	0	970,640	17	25	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	76,170	76,170	6,086,563	82	94,991	30.00
31.00	03100	INTENSIVE CARE UNIT	7,371	7,371	2,486,878	27	90,311	31.00
40.00	04000	SUBPROVIDER - IPF	16,344	16,344	345,342	10	4,197	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	387,501	0	4,289	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,041	28,041	2,195,862	70	77,865	50.00
51.00	05100	RECOVERY ROOM	0	0	490,078	14	6,457	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,273	15,273	597,878	14	30,381	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,839	27,839	2,318,036	50	36,161	54.00
59.00	05900	CARDIAC CATHETERIZATION	6,400	6,400	526,274	21	8,369	59.00
60.00	06000	LABORATORY	11,448	11,448	1,516,884	36	1,108,966	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	44,515	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	115,929	3	9,445	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	941,057	0	4,172	65.00
66.00	06600	PHYSICAL THERAPY	0	0	487,341	7	791	66.00
69.00	06900	ELECTROCARDIOLOGY	3,792	3,792	305,208	12	3,150	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	616	616	33,615	5	259	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	0	63,425	0	38	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	20,280	20,280	1,918,762	51	63,373	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	376,361	376,361	31,669,744	908	1,729,064	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	816	816	0	4	0	190.00
194.00	07950	SIRH	0	0	131,862	0	1,316	194.00
194.01	07951	OTHER NRCC	2,268	2,268	25,738	106	99	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,177,789	4,670,414	7,904,146	402,340	845,029	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.374834	12.308540	0.248345	395.225933	0.488321	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	0	40,871	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000000	0.023618	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet B-1 | Date/Time Prepared: 12/31/2015 9:20 am

		Cost Center Description	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	PURCHASING						5.02
5.03	00570	ADMITTING	261,139,287					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	261,139,287				5.04
5.05	00591	OTHER A&G	0	0	-15,931,311	71,468,949		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	5,366,154	247,943	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	574,552	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	1,311,536	0	9.00
10.00	01000	DIETARY	0	0	0	1,825,913	18,333	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	397,427	3,136	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	469,461	6,072	14.00
15.00	01500	PHARMACY	0	0	0	6,213,882	3,744	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,264,197	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	1,401,619	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	101,337	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,634,567	13,634,567	0	9,693,811	76,170	30.00
31.00	03100	INTENSIVE CARE UNIT	5,106,443	5,106,443	0	3,514,578	7,371	31.00
40.00	04000	SUBPROVIDER - IPF	997,393	997,393	0	800,850	16,344	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	660,155	660,155	0	499,135	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,626,372	21,626,372	0	4,801,180	28,041	50.00
51.00	05100	RECOVERY ROOM	3,327,421	3,327,421	0	667,879	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,283,586	1,283,586	0	1,139,839	15,273	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,698,913	54,698,913	0	4,856,072	27,839	54.00
59.00	05900	CARDIAC CATHETERIZATION	8,843,736	8,843,736	0	978,151	6,400	59.00
60.00	06000	LABORATORY	28,486,153	28,486,153	0	5,264,863	11,448	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	11,210,335	11,210,335	0	189,072	0	63.00
64.00	06400	INTRAVENOUS THERAPY	7,541,043	7,541,043	0	436,462	0	64.00
65.00	06500	RESPIRATORY THERAPY	13,727,894	13,727,894	0	1,888,531	0	65.00
66.00	06600	PHYSICAL THERAPY	1,921,664	1,921,664	0	635,240	0	66.00
69.00	06900	ELECTROCARDIOLOGY	6,830,689	6,830,689	0	550,555	3,792	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,148,541	1,148,541	0	99,627	616	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,177,869	33,177,869	0	7,661,135	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,528,337	11,528,337	0	4,278,736	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,358,970	20,358,970	0	220,162	0	73.00
74.00	07400	RENAL DIALYSIS	287,562	287,562	0	264,471	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	341,242	341,242	0	87,107	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	14,400,402	14,400,402	0	3,335,197	20,280	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	261,139,287	261,139,287	-15,931,311	70,788,731	244,859	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	18,459	816	190.00
194.00	07950	SIRH	0	0	0	199,222	0	194.00
194.01	07951	OTHER NRCC	0	0	0	462,537	2,268	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,189,592	1,634,374		15,931,311	6,562,334	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004555	0.006259		0.222912	26.467107	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	301,807	445,954		724,812	1,261,190	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001156	0.001708		0.010142	5.086613	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet B-1 | Date/Time Prepared: 12/31/2015 9:20 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	PURCHASING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00591	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	685,902					8.00
9.00	00900	HOUSEKEEPING	0	2,580				9.00
10.00	01000	DIETARY	0	6	363,294			10.00
11.00	01100	CAFETERIA	0	0	274,197	1,068,841		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	8,143	695,905	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23	0	0	11,757	14.00
15.00	01500	PHARMACY	0	8	0	57,507	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5	0	43,997	0	16.00
17.00	01700	SOCIAL SERVICE	0	1	0	33,891	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	394,030	1,340	76,895	300,319	300,319	30.00
31.00	03100	INTENSIVE CARE UNIT	123,340	373	9,954	114,850	114,850	31.00
40.00	04000	SUBPROVIDER - IPF	117,498	149	952	18,345	18,345	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	39,649	1	0	13,896	13,896	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	100	0	86,121	86,121	50.00
51.00	05100	RECOVERY ROOM	4,393	0	238	19,656	19,656	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,496	149	147	25,586	25,586	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	68	0	93,153	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	161	29	0	16,859	16,859	59.00
60.00	06000	LABORATORY	0	47	0	69,309	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1	0	3,653	3,653	64.00
65.00	06500	RESPIRATORY THERAPY	0	1	0	40,275	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2	0	13,931	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5	0	12,075	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1	0	1,402	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	2	0	3,654	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,335	269	911	84,863	84,863	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	685,902	2,580	363,294	1,061,485	695,905	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	SIRH	0	0	0	5,746	0	194.00
194.01	07951	OTHER NRCC	0	0	0	1,610	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	702,627	1,603,893	2,721,882	2,054,347	584,670	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.024384	621.663953	7.492229	1.922032	0.840158	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,016	14,588	491,407	370,891	87,677	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.008771	5.654264	1.352643	0.347003	0.125990	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet B-1 | Date/Time Prepared: 12/31/2015 9:20 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	Reconciliation	SOCIAL SERVICE (ACCUM. COST)	
			14.00	15.00	16.00	17A	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	PURCHASING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00591	OTHER A&G						5.05
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	100					14.00
15.00	01500	PHARMACY	0	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	30,822			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	-1,779,819	85,620,441	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	123,926	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,787	0	16,660,746	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	520	0	5,270,715	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	145	0	1,690,430	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	1,122	0	749,490	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	3,291	0	7,088,068	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	877,333	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	86	0	1,970,696	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	12,573	0	7,563,094	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	484	0	1,455,997	59.00
60.00	06000	LABORATORY	0	0	761	0	6,944,227	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	231,218	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	544,467	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	2,387,539	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	804,862	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	799,960	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	141,456	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	64	0	0	0	9,854,650	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	36	0	0	0	5,505,755	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0	0	8,082,866	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	323,425	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	0	0	0	114,790	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	9,053	0	5,507,122	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100	30,822	-1,779,819	84,692,832	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	44,171	190.00
194.00	07950	SIRH	0	0	0	0	254,675	194.00
194.01	07951	OTHER NRCC	0	0	0	0	628,763	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	758,993	7,813,627	1,633,674		1,779,819	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7,589.930000	78,136.270000	53.003504		0.020787	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	162,847	180,640	28,119		25,982	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,628.470000	1,806.400000	0.912303		0.000303	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet B-1 | Date/Time Prepared: 12/31/2015 9:20 am

		Cost Center Description	INTERNS & RESIDENTS			
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
			21.00	22.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	NONPATIENT TELEPHONES				5.01
5.02	00590	PURCHASING				5.02
5.03	00570	ADMITTING				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.04
5.05	00591	OTHER A&G				5.05
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	100			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		100		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	100	100		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		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
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	SIRH	0	0		194.00
194.01	07951	OTHER NRCC	0	0		194.01
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	126,502		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	1,265.020000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	1,066		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	10.660000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet C Part I Date/Time Prepared: 12/31/2015 9:20 am

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	17,007,098		17,007,098	0	17,007,098	30.00
31.00	03100	INTENSIVE CARE UNIT	5,380,277		5,380,277	0	5,380,277	31.00
40.00	04000	SUBPROVIDER - IPF	1,725,569		1,725,569	0	1,725,569	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	765,070		765,070	0	765,070	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,235,408		7,235,408	0	7,235,408	50.00
51.00	05100	RECOVERY ROOM	895,570		895,570	0	895,570	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,011,661		2,011,661	0	2,011,661	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,720,308		7,720,308	0	7,720,308	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,486,263		1,486,263	0	1,486,263	59.00
60.00	06000	LABORATORY	7,088,577		7,088,577	0	7,088,577	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	236,024		236,024	0	236,024	63.00
64.00	06400	INTRAVENOUS THERAPY	555,785		555,785	0	555,785	64.00
65.00	06500	RESPIRATORY THERAPY	2,437,169	0	2,437,169	0	2,437,169	65.00
66.00	06600	PHYSICAL THERAPY	821,593	0	821,593	0	821,593	66.00
69.00	06900	ELECTROCARDIOLOGY	816,589		816,589	0	816,589	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	144,396		144,396	0	144,396	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,059,499		10,059,499	0	10,059,499	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,620,203		5,620,203	0	5,620,203	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,250,885		8,250,885	0	8,250,885	73.00
74.00	07400	RENAL DIALYSIS	330,148		330,148	0	330,148	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	117,176		117,176	0	117,176	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,621,599		5,621,599	0	5,621,599	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,645,661		1,645,661		1,645,661	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	87,972,528	0	87,972,528	0	87,972,528	200.00
201.00		Less Observation Beds	1,645,661		1,645,661		1,645,661	201.00
202.00		Total (see instructions)	86,326,867	0	86,326,867	0	86,326,867	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet C Part I Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,610,334		12,610,334			30.00
31.00	03100	INTENSIVE CARE UNIT	5,106,443		5,106,443			31.00
40.00	04000	SUBPROVIDER - IPF	997,393		997,393			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	660,155		660,155			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,097,397	15,528,975	21,626,372	0.334564	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,421,797	1,905,624	3,327,421	0.269148	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,136,258	147,328	1,283,586	1.567219	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,071,372	39,627,541	54,698,913	0.141142	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	4,940,923	3,902,813	8,843,736	0.168058	0.000000	59.00
60.00	06000	LABORATORY	16,624,716	11,861,437	28,486,153	0.248843	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,013,592	4,196,743	11,210,335	0.021054	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	3,090,804	4,450,239	7,541,043	0.073701	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	10,263,379	3,464,515	13,727,894	0.177534	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,813,336	108,328	1,921,664	0.427542	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	3,411,929	3,418,760	6,830,689	0.119547	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182,462	966,079	1,148,541	0.125721	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,931,619	12,246,250	33,177,869	0.303199	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,671,798	2,856,539	11,528,337	0.487512	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,398,066	7,960,904	20,358,970	0.405270	0.000000	73.00
74.00	07400	RENAL DIALYSIS	281,782	5,780	287,562	1.148093	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	PARTIAL HOSPITALIZATION	2,665	338,577	341,242	0.343381	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,850,660	10,549,742	14,400,402	0.390378	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	176,500	847,733	1,024,233	1.606725	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	136,755,380	124,383,907	261,139,287			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	136,755,380	124,383,907	261,139,287			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet C Part I Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
40.00	04000	SUBPROVIDER - IPF	
41.00	04100	SUBPROVIDER - IRF	
42.00	04200	SUBPROVIDER	
43.00	04300	NURSERY	
44.00	04400	SKILLED NURSING FACILITY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.334564
51.00	05100	RECOVERY ROOM	0.269148
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.567219
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141142
59.00	05900	CARDIAC CATHETERIZATION	0.168058
60.00	06000	LABORATORY	0.248843
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.021054
64.00	06400	INTRAVENOUS THERAPY	0.073701
65.00	06500	RESPIRATORY THERAPY	0.177534
66.00	06600	PHYSICAL THERAPY	0.427542
69.00	06900	ELECTROCARDIOLOGY	0.119547
70.00	07000	ELECTROENCEPHALOGRAPHY	0.125721
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303199
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.487512
73.00	07300	DRUGS CHARGED TO PATIENTS	0.405270
74.00	07400	RENAL DIALYSIS	1.148093
76.00	03950	ANCILLARY	0.000000
76.01	03951	PARTIAL HOSPITALIZATION	0.343381
		OUTPATIENT SERVICE COST CENTERS	
91.00	09100	EMERGENCY	0.390378
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.606725
		SPECIAL PURPOSE COST CENTERS	
113.00	11300	INTEREST EXPENSE	
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet C Part I Date/Time Prepared: 12/31/2015 9:20 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,007,098		17,007,098	0	17,007,098	30.00
31.00	03100	INTENSIVE CARE UNIT	5,380,277		5,380,277	0	5,380,277	31.00
40.00	04000	SUBPROVIDER - IPF	1,725,569		1,725,569	0	1,725,569	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	765,070		765,070	0	765,070	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,235,408		7,235,408	0	7,235,408	50.00
51.00	05100	RECOVERY ROOM	895,570		895,570	0	895,570	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,011,661		2,011,661	0	2,011,661	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,720,308		7,720,308	0	7,720,308	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,486,263		1,486,263	0	1,486,263	59.00
60.00	06000	LABORATORY	7,088,577		7,088,577	0	7,088,577	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	236,024		236,024	0	236,024	63.00
64.00	06400	INTRAVENOUS THERAPY	555,785		555,785	0	555,785	64.00
65.00	06500	RESPIRATORY THERAPY	2,437,169	0	2,437,169	0	2,437,169	65.00
66.00	06600	PHYSICAL THERAPY	821,593	0	821,593	0	821,593	66.00
69.00	06900	ELECTROCARDIOLOGY	816,589		816,589	0	816,589	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	144,396		144,396	0	144,396	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,059,499		10,059,499	0	10,059,499	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,620,203		5,620,203	0	5,620,203	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,250,885		8,250,885	0	8,250,885	73.00
74.00	07400	RENAL DIALYSIS	330,148		330,148	0	330,148	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	117,176		117,176	0	117,176	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,621,599		5,621,599	0	5,621,599	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,645,661		1,645,661		1,645,661	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	87,972,528	0	87,972,528	0	87,972,528	200.00
201.00		Less Observation Beds	1,645,661		1,645,661		1,645,661	201.00
202.00		Total (see instructions)	86,326,867	0	86,326,867	0	86,326,867	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet C Part I Date/Time Prepared: 12/31/2015 9:20 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,610,334		12,610,334			30.00
31.00	03100	INTENSIVE CARE UNIT	5,106,443		5,106,443			31.00
40.00	04000	SUBPROVIDER - IPF	997,393		997,393			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	660,155		660,155			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,097,397	15,528,975	21,626,372	0.334564	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,421,797	1,905,624	3,327,421	0.269148	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,136,258	147,328	1,283,586	1.567219	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,071,372	39,627,541	54,698,913	0.141142	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	4,940,923	3,902,813	8,843,736	0.168058	0.000000	59.00
60.00	06000	LABORATORY	16,624,716	11,861,437	28,486,153	0.248843	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,013,592	4,196,743	11,210,335	0.021054	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	3,090,804	4,450,239	7,541,043	0.073701	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	10,263,379	3,464,515	13,727,894	0.177534	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,813,336	108,328	1,921,664	0.427542	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	3,411,929	3,418,760	6,830,689	0.119547	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182,462	966,079	1,148,541	0.125721	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,931,619	12,246,250	33,177,869	0.303199	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,671,798	2,856,539	11,528,337	0.487512	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,398,066	7,960,904	20,358,970	0.405270	0.000000	73.00
74.00	07400	RENAL DIALYSIS	281,782	5,780	287,562	1.148093	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	PARTIAL HOSPITALIZATION	2,665	338,577	341,242	0.343381	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,850,660	10,549,742	14,400,402	0.390378	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	176,500	847,733	1,024,233	1.606725	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	136,755,380	124,383,907	261,139,287			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	136,755,380	124,383,907	261,139,287			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet C Part I Date/Time Prepared: 12/31/2015 9:20 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.334564	50.00
51.00	05100	RECOVERY ROOM	0.269148	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.567219	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141142	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.168058	59.00
60.00	06000	LABORATORY	0.248843	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.021054	63.00
64.00	06400	INTRAVENOUS THERAPY	0.073701	64.00
65.00	06500	RESPIRATORY THERAPY	0.177534	65.00
66.00	06600	PHYSICAL THERAPY	0.427542	66.00
69.00	06900	ELECTROCARDIOLOGY	0.119547	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.125721	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303199	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.487512	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.405270	73.00
74.00	07400	RENAL DIALYSIS	1.148093	74.00
76.00	03950	ANCILLARY	0.000000	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0.343381	76.01
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.390378	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.606725	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet C Part II Date/Time Prepared: 12/31/2015 9:20 am

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		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,235,408	881,537	6,353,871	0	0	50.00
51.00	05100	RECOVERY ROOM	895,570	26,380	869,190	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,011,661	423,388	1,588,273	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,720,308	970,503	6,749,805	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,486,263	209,396	1,276,867	0	0	59.00
60.00	06000	LABORATORY	7,088,577	483,300	6,605,277	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	236,024	35,145	200,879	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	555,785	28,146	527,639	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,437,169	73,273	2,363,896	0	0	65.00
66.00	06600	PHYSICAL THERAPY	821,593	17,054	804,539	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	816,589	127,400	689,189	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	144,396	20,715	123,681	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,059,499	279,929	9,779,570	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,620,203	136,705	5,483,498	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,250,885	243,630	8,007,255	0	0	73.00
74.00	07400	RENAL DIALYSIS	330,148	3,603	326,545	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	117,176	3,175	114,001	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,621,599	652,032	4,969,567	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,645,661	229,058	1,416,603	0	0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	63,094,514	4,844,369	58,250,145	0	0	200.00
201.00		Less Observation Beds	1,645,661	229,058	1,416,603	0	0	201.00
202.00		Total (line 200 minus line 201)	61,448,853	4,615,311	56,833,542	0	0	202.00

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

Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet C Part II | Date/Time Prepared: 12/31/2015 9:20 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	7,235,408	21,626,372	0.334564		50.00
51.00	05100	RECOVERY ROOM	895,570	3,327,421	0.269148		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,011,661	1,283,586	1.567219		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,720,308	54,698,913	0.141142		54.00
59.00	05900	CARDIAC CATHETERIZATION	1,486,263	8,843,736	0.168058		59.00
60.00	06000	LABORATORY	7,088,577	28,486,153	0.248843		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	236,024	11,210,335	0.021054		63.00
64.00	06400	INTRAVENOUS THERAPY	555,785	7,541,043	0.073701		64.00
65.00	06500	RESPIRATORY THERAPY	2,437,169	13,727,894	0.177534		65.00
66.00	06600	PHYSICAL THERAPY	821,593	1,921,664	0.427542		66.00
69.00	06900	ELECTROCARDIOLOGY	816,589	6,830,689	0.119547		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	144,396	1,148,541	0.125721		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,059,499	33,177,869	0.303199		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,620,203	11,528,337	0.487512		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,250,885	20,358,970	0.405270		73.00
74.00	07400	RENAL DIALYSIS	330,148	287,562	1.148093		74.00
76.00	03950	ANCILLARY	0	0	0.000000		76.00
76.01	03951	PARTIAL HOSPITALIZATION	117,176	341,242	0.343381		76.01
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	5,621,599	14,400,402	0.390378		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,645,661	1,024,233	1.606725		92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	63,094,514	241,764,962			200.00
201.00		Less Observation Beds	1,645,661	0			201.00
202.00		Total (line 200 minus line 201)	61,448,853	241,764,962			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part I Date/Time Prepared: 12/31/2015 9:20 am

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	2,367,206	0	2,367,206	23,263	101.76	30.00
31.00	INTENSIVE CARE UNIT	315,402		315,402	5,360	58.84	31.00
40.00	SUBPROVIDER - IPF	444,745	0	444,745	1,728	257.38	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	15,232		15,232	1,724	8.84	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	3,142,585		3,142,585	32,075		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	9,162	932,325	30.00
31.00	INTENSIVE CARE UNIT	2,778	163,458	31.00
40.00	SUBPROVIDER - IPF	1,389	357,501	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	13,329	1,453,284	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part II Date/Time Prepared: 12/31/2015 9:20 am

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	881,537	21,626,372	0.040762	2,728,551	111,221	50.00
51.00	05100	RECOVERY ROOM	26,380	3,327,421	0.007928	660,333	5,235	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	423,388	1,283,586	0.329848	5,315	1,753	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	970,503	54,698,913	0.017743	7,317,747	129,839	54.00
59.00	05900	CARDIAC CATHETERIZATION	209,396	8,843,736	0.023677	2,067,201	48,945	59.00
60.00	06000	LABORATORY	483,300	28,486,153	0.016966	7,760,741	131,669	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	35,145	11,210,335	0.003135	3,172,334	9,945	63.00
64.00	06400	INTRAVENOUS THERAPY	28,146	7,541,043	0.003732	1,507,443	5,626	64.00
65.00	06500	RESPIRATORY THERAPY	73,273	13,727,894	0.005338	5,922,675	31,615	65.00
66.00	06600	PHYSICAL THERAPY	17,054	1,921,664	0.008875	1,012,887	8,989	66.00
69.00	06900	ELECTROCARDIOLOGY	127,400	6,830,689	0.018651	1,824,567	34,030	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,715	1,148,541	0.018036	96,162	1,734	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	279,929	33,177,869	0.008437	9,694,255	81,790	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	136,705	11,528,337	0.011858	4,252,709	50,429	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	243,630	20,358,970	0.011967	5,634,282	67,425	73.00
74.00	07400	RENAL DIALYSIS	3,603	287,562	0.012529	151,949	1,904	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	3,175	341,242	0.009304	1,990	19	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	652,032	14,400,402	0.045279	1,718,993	77,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	229,058	1,024,233	0.223639	78,188	17,486	92.00
200.00		Total (lines 50-199)	4,844,369	241,764,962		55,608,322	817,488	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part III Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0		0	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	23,263	0.00	9,162	0		30.00
31.00	03100	INTENSIVE CARE UNIT	5,360	0.00	2,778	0		31.00
40.00	04000	SUBPROVIDER - IPF	1,728	0.00	1,389	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	1,724	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	32,075		13,329	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part IV Date/Time Prepared: 12/31/2015 9:20 am

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
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part IV Date/Time Prepared: 12/31/2015 9:20 am

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	21,626,372	0.000000	0.000000	2,728,551	50.00
51.00	05100	RECOVERY ROOM	0	3,327,421	0.000000	0.000000	660,333	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,283,586	0.000000	0.000000	5,315	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,698,913	0.000000	0.000000	7,317,747	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	8,843,736	0.000000	0.000000	2,067,201	59.00
60.00	06000	LABORATORY	0	28,486,153	0.000000	0.000000	7,760,741	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	11,210,335	0.000000	0.000000	3,172,334	63.00
64.00	06400	INTRAVENOUS THERAPY	0	7,541,043	0.000000	0.000000	1,507,443	64.00
65.00	06500	RESPIRATORY THERAPY	0	13,727,894	0.000000	0.000000	5,922,675	65.00
66.00	06600	PHYSICAL THERAPY	0	1,921,664	0.000000	0.000000	1,012,887	66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,830,689	0.000000	0.000000	1,824,567	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,148,541	0.000000	0.000000	96,162	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	33,177,869	0.000000	0.000000	9,694,255	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	11,528,337	0.000000	0.000000	4,252,709	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,358,970	0.000000	0.000000	5,634,282	73.00
74.00	07400	RENAL DIALYSIS	0	287,562	0.000000	0.000000	151,949	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	341,242	0.000000	0.000000	1,990	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	14,400,402	0.000000	0.000000	1,718,993	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,024,233	0.000000	0.000000	78,188	92.00
200.00		Total (lines 50-199)	0	241,764,962			55,608,322	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part IV Date/Time Prepared: 12/31/2015 9:20 am

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	4,975,639	0		50.00
51.00	05100	RECOVERY ROOM	0	245,556	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	381	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,896,026	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,768,695	0		59.00
60.00	06000	LABORATORY	0	2,295,142	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	780,368	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,320,408	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	395,825	0		65.00
66.00	06600	PHYSICAL THERAPY	0	659	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,431,350	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	264,006	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,648,963	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,232,082	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,602,700	0		73.00
74.00	07400	RENAL DIALYSIS	0	4,105	0		74.00
76.00	03950	ANCILLARY	0	0	0		76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	69,389	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	2,324,572	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,280,216	0		92.00
200.00		Total (lines 50-199)	0	36,536,082	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part V Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.334564	4,975,639	0	0	1,664,670	50.00
51.00	05100	RECOVERY ROOM	0.269148	245,556	0	0	66,091	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.567219	381	0	0	597	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141142	11,896,026	0	0	1,679,029	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.168058	1,768,695	0	0	297,243	59.00
60.00	06000	LABORATORY	0.248843	2,295,142	702	0	571,130	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.021054	780,368	0	0	16,430	63.00
64.00	06400	INTRAVENOUS THERAPY	0.073701	1,320,408	0	0	97,315	64.00
65.00	06500	RESPIRATORY THERAPY	0.177534	395,825	0	0	70,272	65.00
66.00	06600	PHYSICAL THERAPY	0.427542	659	0	0	282	66.00
69.00	06900	ELECTROCARDIOLOGY	0.119547	1,431,350	0	0	171,114	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.125721	264,006	0	0	33,191	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303199	3,648,963	0	0	1,106,362	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.487512	1,232,082	0	0	600,655	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.405270	2,602,700	12,619	0	1,054,796	73.00
74.00	07400	RENAL DIALYSIS	1.148093	4,105	0	0	4,713	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0.343381	69,389	0	0	23,827	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.390378	2,324,572	0	0	907,462	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.606725	1,280,216	0	0	2,056,955	92.00
200.00		Subtotal (see instructions)		36,536,082	13,321	0	10,422,134	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		36,536,082	13,321	0	10,422,134	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part V Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	175	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,114	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	5,289	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,289	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part II Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	881,537	21,626,372	0.040762	0	0	50.00
51.00	05100	RECOVERY ROOM	26,380	3,327,421	0.007928	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	423,388	1,283,586	0.329848	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	970,503	54,698,913	0.017743	101,517	1,801	54.00
59.00	05900	CARDIAC CATHETERIZATION	209,396	8,843,736	0.023677	0	0	59.00
60.00	06000	LABORATORY	483,300	28,486,153	0.016966	485,085	8,230	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	35,145	11,210,335	0.003135	52,230	164	63.00
64.00	06400	INTRAVENOUS THERAPY	28,146	7,541,043	0.003732	3,923	15	64.00
65.00	06500	RESPIRATORY THERAPY	73,273	13,727,894	0.005338	24,894	133	65.00
66.00	06600	PHYSICAL THERAPY	17,054	1,921,664	0.008875	37,501	333	66.00
69.00	06900	ELECTROCARDIOLOGY	127,400	6,830,689	0.018651	9,612	179	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,715	1,148,541	0.018036	5,614	101	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	279,929	33,177,869	0.008437	106,910	902	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	136,705	11,528,337	0.011858	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	243,630	20,358,970	0.011967	201,302	2,409	73.00
74.00	07400	RENAL DIALYSIS	3,603	287,562	0.012529	2,720	34	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	3,175	341,242	0.009304	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	652,032	14,400,402	0.045279	25,073	1,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,024,233	0.000000	0	0	92.00
200.00		Total (lines 50-199)	4,615,311	241,764,962		1,056,381	15,436	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part IV | Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part IV Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	21,626,372	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	3,327,421	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,283,586	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,698,913	0.000000	0.000000	101,517	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	8,843,736	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	28,486,153	0.000000	0.000000	485,085	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	11,210,335	0.000000	0.000000	52,230	63.00
64.00	06400	INTRAVENOUS THERAPY	0	7,541,043	0.000000	0.000000	3,923	64.00
65.00	06500	RESPIRATORY THERAPY	0	13,727,894	0.000000	0.000000	24,894	65.00
66.00	06600	PHYSICAL THERAPY	0	1,921,664	0.000000	0.000000	37,501	66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,830,689	0.000000	0.000000	9,612	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,148,541	0.000000	0.000000	5,614	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	33,177,869	0.000000	0.000000	106,910	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	11,528,337	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,358,970	0.000000	0.000000	201,302	73.00
74.00	07400	RENAL DIALYSIS	0	287,562	0.000000	0.000000	2,720	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	341,242	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	14,400,402	0.000000	0.000000	25,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,024,233	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	241,764,962			1,056,381	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part IV | Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	ANCILLARY	0	0	0		76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part V | Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.334564	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.269148	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.567219	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141142	0	6,962	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.168058	0	0	0	0	59.00
60.00	06000	LABORATORY	0.248843	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.021054	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.073701	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.177534	0	1,607	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.427542	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.119547	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.125721	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303199	0	1,331	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.487512	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.405270	0	315	0	0	73.00
74.00	07400	RENAL DIALYSIS	1.148093	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0.343381	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.390378	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.606725	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	10,215	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	10,215	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part V | Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	983	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	285	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	404	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	128	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	1,800	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,800	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part I Date/Time Prepared: 12/31/2015 9:20 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,367,206	0	2,367,206	23,263	101.76	30.00
31.00	INTENSIVE CARE UNIT	315,402		315,402	5,360	58.84	31.00
40.00	SUBPROVIDER - IPF	444,745	0	444,745	1,728	257.38	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	15,232		15,232	1,724	8.84	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	3,142,585		3,142,585	32,075		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	1,682	171,160	30.00
31.00	INTENSIVE CARE UNIT	429	25,242	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	138	1,220	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	2,249	197,622	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part II Date/Time Prepared: 12/31/2015 9:20 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	881,537	21,626,372	0.040762	1,564,305	63,764	50.00
51.00	05100	RECOVERY ROOM	26,380	3,327,421	0.007928	108,260	858	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	423,388	1,283,586	0.329848	706,752	233,121	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	970,503	54,698,913	0.017743	1,694,343	30,063	54.00
59.00	05900	CARDIAC CATHETERIZATION	209,396	8,843,736	0.023677	0	0	59.00
60.00	06000	LABORATORY	483,300	28,486,153	0.016966	3,213,517	54,521	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	35,145	11,210,335	0.003135	59,496	187	63.00
64.00	06400	INTRAVENOUS THERAPY	28,146	7,541,043	0.003732	529,104	1,975	64.00
65.00	06500	RESPIRATORY THERAPY	73,273	13,727,894	0.005338	1,340,972	7,158	65.00
66.00	06600	PHYSICAL THERAPY	17,054	1,921,664	0.008875	79,468	705	66.00
69.00	06900	ELECTROCARDIOLOGY	127,400	6,830,689	0.018651	306,395	5,715	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,715	1,148,541	0.018036	19,365	349	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	279,929	33,177,869	0.008437	846,165	7,139	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	136,705	11,528,337	0.011858	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	243,630	20,358,970	0.011967	1,508,246	18,049	73.00
74.00	07400	RENAL DIALYSIS	3,603	287,562	0.012529	56,457	707	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	3,175	341,242	0.009304	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	652,032	14,400,402	0.045279	819,680	37,114	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	229,058	1,024,233	0.223639	0	0	92.00
200.00		Total (lines 50-199)	4,844,369	241,764,962		12,852,525	461,425	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part III Date/Time Prepared: 12/31/2015 9:20 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0		0	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	23,263	0.00	1,682	0		30.00
31.00	03100	INTENSIVE CARE UNIT	5,360	0.00	429	0		31.00
40.00	04000	SUBPROVIDER - IPF	1,728	0.00	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	1,724	0.00	138	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	32,075		2,249	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part IV | Date/Time Prepared: 12/31/2015 9:20 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part IV Date/Time Prepared: 12/31/2015 9:20 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	21,626,372	0.000000	0.000000	1,564,305	50.00
51.00	05100	RECOVERY ROOM	0	3,327,421	0.000000	0.000000	108,260	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,283,586	0.000000	0.000000	706,752	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,698,913	0.000000	0.000000	1,694,343	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	8,843,736	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	28,486,153	0.000000	0.000000	3,213,517	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	11,210,335	0.000000	0.000000	59,496	63.00
64.00	06400	INTRAVENOUS THERAPY	0	7,541,043	0.000000	0.000000	529,104	64.00
65.00	06500	RESPIRATORY THERAPY	0	13,727,894	0.000000	0.000000	1,340,972	65.00
66.00	06600	PHYSICAL THERAPY	0	1,921,664	0.000000	0.000000	79,468	66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,830,689	0.000000	0.000000	306,395	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,148,541	0.000000	0.000000	19,365	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	33,177,869	0.000000	0.000000	846,165	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	11,528,337	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,358,970	0.000000	0.000000	1,508,246	73.00
74.00	07400	RENAL DIALYSIS	0	287,562	0.000000	0.000000	56,457	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	341,242	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	14,400,402	0.000000	0.000000	819,680	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,024,233	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	241,764,962			12,852,525	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part IV | Date/Time Prepared: 12/31/2015 9:20 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	ANCILLARY	0	0	0		76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part V Date/Time Prepared: 12/31/2015 9:20 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.334564	0	2,308,966	0	0	50.00
51.00	05100	RECOVERY ROOM	0.269148	0	270,550	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.567219	0	165,412	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141142	0	5,226,267	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.168058	0	255,643	0	0	59.00
60.00	06000	LABORATORY	0.248843	0	2,979,469	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.021054	0	32,492	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.073701	0	283,409	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.177534	0	398,224	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.427542	0	4,672	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.119547	0	215,546	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.125721	0	173,461	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303199	0	547,424	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.487512	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.405270	0	549,786	0	0	73.00
74.00	07400	RENAL DIALYSIS	1.148093	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0.343381	0	71,529	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.390378	0	3,219,256	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.606725	0	167,213	0	0	92.00
200.00		Subtotal (see instructions)		0	16,869,319	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	16,869,319	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D Part V Date/Time Prepared: 12/31/2015 9:20 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	772,497	0		50.00
51.00	05100	RECOVERY ROOM	72,818	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	259,237	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	737,646	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	42,963	0		59.00
60.00	06000	LABORATORY	741,420	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	684	0		63.00
64.00	06400	INTRAVENOUS THERAPY	20,888	0		64.00
65.00	06500	RESPIRATORY THERAPY	70,698	0		65.00
66.00	06600	PHYSICAL THERAPY	1,997	0		66.00
69.00	06900	ELECTROCARDIOLOGY	25,768	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21,808	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	165,978	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	222,812	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03951	PARTIAL HOSPITALIZATION	24,562	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,256,727	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	268,665	0		92.00
200.00		Subtotal (see instructions)	4,707,168	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,707,168	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D-1 | Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	23,263	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	23,263	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	21,012	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)	9,162	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)	17,007,098	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)	17,007,098	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	17,007,098	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)	731.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,698,155	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)	6,698,155	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D-1 | Date/Time Prepared: 12/31/2015 9:20 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,380,277	5,360	1,003.78	2,778	2,788,501	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	14,570,778	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	24,057,434	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,095,783	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	817,488	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,913,271	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	22,144,163	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,251	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	731.08	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,645,661	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D-1 | Date/Time Prepared: 12/31/2015 9:20 am

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	2,367,206	17,007,098	0.139189	1,645,661	229,058	90.00
91.00	Nursing School cost	0	17,007,098	0.000000	1,645,661	0	91.00
92.00	Allied health cost	0	17,007,098	0.000000	1,645,661	0	92.00
93.00	All other Medical Education	0	17,007,098	0.000000	1,645,661	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150009 Component CCN: 15S009	Period: From 01/01/2015 To 07/31/2015	Worksheet D-1 Date/Time Prepared: 12/31/2015 9:20 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,728	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,728	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,728	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)	1,389	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)	1,725,569	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)	1,725,569	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,725,569	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)	998.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,387,042	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)	1,387,042	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D-1 | Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	285,643	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,672,685	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)	357,501	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	15,436	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	372,937	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,299,748	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D-1 | Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	444,745	1,725,569	0.257738	0	0	90.00
91.00	Nursing School cost	0	1,725,569	0.000000	0	0	91.00
92.00	Allied health cost	0	1,725,569	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,725,569	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D-1 | Date/Time Prepared: 12/31/2015 9:20 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	23,263	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	23,263	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	21,012	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)	1,682	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)	1,724	15.00
16.00	Nursery days (title V or XIX only)	138	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)	17,007,098	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)	17,007,098	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	17,007,098	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)	731.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,229,677	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)	1,229,677	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D-1 | Date/Time Prepared: 12/31/2015 9:20 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	765,070	1,724	443.78	138	61,242	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,380,277	5,360	1,003.78	429	430,622	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)	4,302,899	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,024,440	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)	197,622	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	461,425	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	659,047	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,365,393	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,251	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	731.08	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,645,661	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D-1 | Date/Time Prepared: 12/31/2015 9:20 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,367,206	17,007,098	0.139189	1,645,661	229,058	90.00
91.00	Nursing School cost	0	17,007,098	0.000000	1,645,661	0	91.00
92.00	Allied health cost	0	17,007,098	0.000000	1,645,661	0	92.00
93.00	All other Medical Education	0	17,007,098	0.000000	1,645,661	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D-3 | Date/Time Prepared: 12/31/2015 9:20 am

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		5,460,814		30.00
31.00	03100	INTENSIVE CARE UNIT		3,026,661		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.334564	2,728,551	912,875	50.00
51.00	05100	RECOVERY ROOM	0.269148	660,333	177,727	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.567219	5,315	8,330	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141142	7,317,747	1,032,841	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.168058	2,067,201	347,410	59.00
60.00	06000	LABORATORY	0.248843	7,760,741	1,931,206	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.021054	3,172,334	66,790	63.00
64.00	06400	INTRAVENOUS THERAPY	0.073701	1,507,443	111,100	64.00
65.00	06500	RESPIRATORY THERAPY	0.177534	5,922,675	1,051,476	65.00
66.00	06600	PHYSICAL THERAPY	0.427542	1,012,887	433,052	66.00
69.00	06900	ELECTROCARDIOLOGY	0.119547	1,824,567	218,122	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.125721	96,162	12,090	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303199	9,694,255	2,939,288	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.487512	4,252,709	2,073,247	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.405270	5,634,282	2,283,405	73.00
74.00	07400	RENAL DIALYSIS	1.148093	151,949	174,452	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0.343381	1,990	683	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.390378	1,718,993	671,057	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.606725	78,188	125,627	92.00
200.00		Total (sum of lines 50-94 and 96-98)		55,608,322	14,570,778	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)		55,608,322		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D-3 | Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		801,125		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.334564	0	0	50.00
51.00	05100	RECOVERY ROOM	0.269148	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.567219	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141142	101,517	14,328	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.168058	0	0	59.00
60.00	06000	LABORATORY	0.248843	485,085	120,710	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.021054	52,230	1,100	63.00
64.00	06400	INTRAVENOUS THERAPY	0.073701	3,923	289	64.00
65.00	06500	RESPIRATORY THERAPY	0.177534	24,894	4,420	65.00
66.00	06600	PHYSICAL THERAPY	0.427542	37,501	16,033	66.00
69.00	06900	ELECTROCARDIOLOGY	0.119547	9,612	1,149	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.125721	5,614	706	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303199	106,910	32,415	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.487512	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.405270	201,302	81,582	73.00
74.00	07400	RENAL DIALYSIS	1.148093	2,720	3,123	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0.343381	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.390378	25,073	9,788	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.606725	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,056,381	285,643	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,056,381		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D-3 | Date/Time Prepared: 12/31/2015 9:20 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,007,237		30.00
31.00	03100	INTENSIVE CARE UNIT		513,501		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		284,823		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.334564	1,564,305	523,360	50.00
51.00	05100	RECOVERY ROOM	0.269148	108,260	29,138	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.567219	706,752	1,107,635	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141142	1,694,343	239,143	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.168058	0	0	59.00
60.00	06000	LABORATORY	0.248843	3,213,517	799,661	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.021054	59,496	1,253	63.00
64.00	06400	INTRAVENOUS THERAPY	0.073701	529,104	38,995	64.00
65.00	06500	RESPIRATORY THERAPY	0.177534	1,340,972	238,068	65.00
66.00	06600	PHYSICAL THERAPY	0.427542	79,468	33,976	66.00
69.00	06900	ELECTROCARDIOLOGY	0.119547	306,395	36,629	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.125721	19,365	2,435	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303199	846,165	256,556	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.487512	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.405270	1,508,246	611,247	73.00
74.00	07400	RENAL DIALYSIS	1.148093	56,457	64,818	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0.343381	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.390378	819,680	319,985	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.606725	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		12,852,525	4,302,899	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)		12,852,525		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet D-3 | Date/Time Prepared: 12/31/2015 9:20 am

Title XIX | Subprovider - IPF

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		35,074		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.334564	0	0	50.00
51.00	05100	RECOVERY ROOM	0.269148	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.567219	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141142	2,685	379	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.168058	0	0	59.00
60.00	06000	LABORATORY	0.248843	20,715	5,155	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.021054	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.073701	897	66	64.00
65.00	06500	RESPIRATORY THERAPY	0.177534	44	8	65.00
66.00	06600	PHYSICAL THERAPY	0.427542	1,770	757	66.00
69.00	06900	ELECTROCARDIOLOGY	0.119547	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.125721	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303199	6,159	1,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.487512	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.405270	19,208	7,784	73.00
74.00	07400	RENAL DIALYSIS	1.148093	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0.343381	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.390378	2,199	858	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.606725	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		53,677	16,874	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)		53,677		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet E Part A Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Hospital | PPS

		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		19,850,531		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		0		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)		202,888		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		4,679,274		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		158.38		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)		4.49		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)		0.86		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)		3.63		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		2.50		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)		2.50		12.00
13.00	Total allowable FTE count for the prior year.		2.24		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.		1.99		14.00
15.00	Sum of lines 12 through 14 divided by 3.		2.24		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		2.24		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.014143		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.014210		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.014143		21.00
22.00	IME payment adjustment (see instructions)		152,849		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		36,030		22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		-1.13		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)		152,849		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		36,030		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		8.20		30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.92		31.00
32.00	Sum of lines 30 and 31		28.12		32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.41		33.00
34.00	Disproportionate share adjustment (see instructions)		615,863		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet E Part A | Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		7,647,644,885	0	35.00
35.01	Factor 3 (see instructions)		0.000334796	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		2,560,421	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,487,149	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,487,149		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		22,309,280		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)		22,345,310		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,687,318		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).		46,565		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		8,172		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)		24,087,365		59.00
60.00	Primary payer payments		186,285		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		23,901,080		61.00
62.00	Deductibles billed to program beneficiaries		2,168,692		62.00
63.00	Coinsurance billed to program beneficiaries		60,480		63.00
64.00	Allowable bad debts (see instructions)		169,217		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		109,991		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		59,775		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		21,781,899		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)		-15,816		70.93
70.94	HRR adjustment amount (see instructions)		-61,561		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150009	Period: From 01/01/2015 To 07/31/2015	Worksheet E Part A Date/Time Prepared: 12/31/2015 9:20 am
	Title XVIII	Hospital	PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		21,704,522		71.00
71.01	Sequestration adjustment (see instructions)		434,090		71.01
72.00	Interim payments		21,090,925		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)		179,507		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		108,731		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150009	Period: From 01/01/2015 To 07/31/2015	Worksheet E Part B Date/Time Prepared: 12/31/2015 9:20 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,289	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	10,422,134	2.00
3.00	PPS payments	8,674,729	3.00
4.00	Outlier payment (see instructions)	1,604	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)	5,289	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	13,321	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)	13,321	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)	13,321	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	8,032	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)	5,289	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)	8,676,333	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,877,324	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)	6,804,298	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	18,996	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)	6,823,294	30.00
31.00	Primary payer payments	8,479	31.00
32.00	Subtotal (line 30 minus line 31)	6,814,815	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)	284,845	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	185,149	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	228,399	36.00
37.00	Subtotal (see instructions)	6,999,964	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS	82	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	7,000,046	40.00
40.01	Sequestration adjustment (see instructions)	140,001	40.01
41.00	Interim payments	6,881,709	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-21,664	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150009 Component CCN: 15S009	Period: From 01/01/2015 To 07/31/2015	Worksheet E Part B Date/Time Prepared: 12/31/2015 9:20 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,800	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	2,036	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,800	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	10,215	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)	10,215	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)	10,215	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	8,415	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	1,800	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)	2,036	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	491	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,345	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,345	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	3,345	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	3,345	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,345	40.00
40.01	Sequestration adjustment (see instructions)	67	40.01
41.00	Interim payments	1,514	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	1,764	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: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet E-1 Part I Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		21,008,825		6,833,409	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	07/17/2015	82,100	07/17/2015	48,300	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)		82,100		48,300	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)		21,090,925		6,881,709	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		179,507		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		21,664	6.02
7.00	Total Medicare program liability (see instructions)		21,270,432		6,860,045	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: 150009 | Component CCN: 15S009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,116,026		1,514	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,116,026		1,514	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		1,764	6.01
6.02	SETTLEMENT TO PROGRAM		25,049		0	6.02
7.00	Total Medicare program liability (see instructions)		1,090,977		3,278	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: 150009	Period: From 01/01/2015 To 07/31/2015	Worksheet E-1 Part II Date/Time Prepared: 12/31/2015 9:20 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	0	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	0	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	0	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	261,168,017	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	0	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150009 Component CCN: 15S009	Period: From 01/01/2015 To 07/31/2015	Worksheet E-3 Part II Date/Time Prepared: 12/31/2015 9:20 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,157,479	1.00
2.00	Net IPF PPS Outlier Payments	49,044	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	8.150943	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,206,523	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,206,523	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,206,523	18.00
19.00	Deductibles	102,016	19.00
20.00	Subtotal (line 18 minus line 19)	1,104,507	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	1,104,507	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	13,438	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	8,735	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,113,242	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,113,242	31.00
31.01	Sequestration adjustment (see instructions)	22,265	31.01
32.00	Interim payments	1,116,026	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	-25,049	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	49,044	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150009	Period: From 01/01/2015 To 07/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 12/31/2015 9:20 am
	Title XIX	Hospital	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		4,707,168	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	4,707,168	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	4,707,168	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	12,852,525	16,869,319	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	12,852,525	16,869,319	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	12,852,525	16,869,319	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	12,852,525	12,162,151	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	4,707,168	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	4,707,168	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	4,707,168	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	4,707,168	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	4,707,168	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	4,707,168	40.00
41.00	Interim payments	0	4,707,168	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet E-4 | Date/Time Prepared: 12/31/2015 9:20 am

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			4.49	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.86	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			3.63	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			2.85	6.00
7.00	Enter the lesser of line 5 or line 6			2.85	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	2.50	0.00	2.50	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	2.50	0.00	2.50	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	2.50	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	2.24	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.45	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	2.06	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	2.06	0.00		17.00
18.00	Per resident amount	56,456.14	0.00		18.00
19.00	Approved amount for resident costs	116,300	0	116,300	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			116,300	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	13,329	2,925		26.00
27.00	Total Inpatient Days (see instructions)	28,100	28,100		27.00
28.00	Ratio of inpatient days to total inpatient days	0.474342	0.104093		28.00
29.00	Program direct GME amount	55,166	12,106		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		1,711		30.00
31.00	Net Program direct GME amount			65,561	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 150009	Period: From 01/01/2015 To 07/31/2015	Worksheet E-4 Date/Time Prepared: 12/31/2015 9:20 am
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	287,562	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	25,730,119	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	186,285	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	25,543,834	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	10,429,223	42.00
43.00	Primary payer payments (see instructions)	8,479	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	10,420,744	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	35,964,578	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.710250	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.289750	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	65,561	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	46,565	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	18,996	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet G | Date/Time Prepared: 12/31/2015 9:20 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,480,502	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	19,323,606	0	0	0	4.00
5.00	Other receivable	780,446	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,050,091	0	0	0	7.00
8.00	Prepaid expenses	1,155,756	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	3,048,094	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	28,838,495	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	5,945,943	0	0	0	12.00
13.00	Land improvements	1,458,980	0	0	0	13.00
14.00	Accumulated depreciation	-1,303,039	0	0	0	14.00
15.00	Buildings	87,157,140	0	0	0	15.00
16.00	Accumulated depreciation	-61,674,679	0	0	0	16.00
17.00	Leasehold improvements	2,107,691	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	21,232,175	0	0	0	19.00
20.00	Accumulated depreciation	-19,004,461	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	110,437,825	0	0	0	23.00
24.00	Accumulated depreciation	-81,030,060	0	0	0	24.00
25.00	Minor equipment depreciable	2,389,229	0	0	0	25.00
26.00	Accumulated depreciation	-851,291	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)	66,865,453	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	6,946,565	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	7,932,407	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,878,972	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	110,582,920	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,121,619	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,064,848	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	2,348,577	0	0	0	43.00
44.00	Other current liabilities	34,309,061	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	43,844,105	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	44,573,962	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	543,636	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	45,117,598	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	88,961,703	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	21,621,217				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)	21,621,217	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	110,582,920	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet G-1 | Date/Time Prepared: 12/31/2015 9:20 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		30,613,660		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-8,992,443				2.00
3.00	Total (sum of line 1 and line 2)		21,621,217		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)		21,621,217		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		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)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		21,621,217		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	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 150009 | Period: From 01/01/2015 To 07/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 12/31/2015 9:20 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	14,547,874		14,547,874	1.00
2.00	SUBPROVIDER - IPF	997,525		997,525	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	15,545,399		15,545,399	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	5,968,184		5,968,184	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,968,184		5,968,184	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	21,513,583		21,513,583	17.00
18.00	Ancillary services	109,515,987	108,127,177	217,643,164	18.00
19.00	Outpatient services	6,452,205	14,087,644	20,539,849	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER	1,120,245	371,082	1,491,327	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	138,602,020	122,585,903	261,187,923	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		90,707,427		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)		90,707,427		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150009	Period: From 01/01/2015 To 07/31/2015	Worksheet G-3 Date/Time Prepared: 12/31/2015 9:20 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	261,187,923	1.00
2.00	Less contractual allowances and discounts on patients' accounts	177,746,875	2.00
3.00	Net patient revenues (line 1 minus line 2)	83,441,048	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	90,707,427	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,266,379	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	120,755	6.00
7.00	Income from investments	71,925	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	-5,710	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	534,264	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	36,282	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	17,348	21.00
22.00	Rental of hospital space	139,210	22.00
23.00	Governmental appropriations	0	23.00
24.00	IDENTIFIED ON TRIAL BALANCE	-2,640,138	24.00
25.00	Total other income (sum of lines 6-24)	-1,726,064	25.00
26.00	Total (line 5 plus line 25)	-8,992,443	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-8,992,443	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150009	Period: From 01/01/2015 To 07/31/2015	Worksheet L Parts I-III Date/Time Prepared: 12/31/2015 9:20 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,566,811	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	20,858	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)	124.40	3.00
4.00	Number of interns & residents (see instructions)	2.24	4.00
5.00	Indirect medical education percentage (see instructions)	0.51	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)	7,991	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	8.20	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	19.92	8.00
9.00	Sum of lines 7 and 8	28.12	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.85	10.00
11.00	Disproportionate share adjustment (see instructions)	91,658	11.00
12.00	Total prospective capital payments (see instructions)	1,687,318	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