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: 151318	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/31/2016 9:11 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/31/2016 Time: 9:11 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 DUKES MEMORIAL HOSPITAL (151318) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-458,093	-1,152,540	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-41,066	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-499,159	-1,152,540	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2016 8:44 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 275 WEST 12TH STREET	PO Box:			1.00
2.00	City: PERU	State: IN	Zip Code: 46970	County: MIAMI	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	DUKES MEMORIAL HOSPITAL	151318	99915	1	07/01/1966	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	DUKES MEMORIAL HOSPITAL SB	15Z318	99915		12/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2015	12/31/2015	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	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: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2016 8:44 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.	2		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.	2		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	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2016 8:44 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: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2016 8:44 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.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

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

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		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.	Y	Y	Y	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.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	10,745	114,114	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: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2016 8:44 am

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS	Contractor's Number: 05001	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	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)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2015	12/31/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151318	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/31/2016 8:44 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: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2016 8:44 am

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	05/19/2016	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2016 8:44 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?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2016 8:44 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)	05/19/2016			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2016 8:44 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	21	7,665	71,592.00	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)		21	7,665	71,592.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	10,872.00	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)		25	9,125	82,464.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						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)		25				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: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2016 8:44 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)	1,560	109	2,983			1.00
2.00	HMO and other (see instructions)	297	0				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	148	0	165			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)	1,708	109	3,148			7.00
8.00	INTENSIVE CARE UNIT	298	0	453			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		0	400			13.00
14.00	Total (see instructions)	2,006	109	4,001	0.00	194.54	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	194.54	27.00
28.00	Observation Bed Days		0	723			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: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2016 8:44 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	538	195	1,127	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	538	195	1,127	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						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: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2016 8:44 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	11,680,318	0	11,680,318	0.00	0.00	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		200,027	74,328	274,355	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	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)		0	0	0			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		0	0	0			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	95,212	0	95,212	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,763,655	33,303	1,796,958	0.00	0.00	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	230,938	753	231,691	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	229,964	0	229,964	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	205,298	-126,284	79,014	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	126,284	126,284	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	297,568	-185,526	112,042	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	75,696	0	75,696	0.00	0.00	39.00
40.00	Pharmacy	15.00	409,158	0	409,158	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2016 8:44 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	143,612	77,142	220,754	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part III Date/Time Prepared: 5/31/2016 8:44 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)		11,680,318	0	11,680,318	0.00	0.00	1.00
2.00	Excluded area salaries (see instructions)		200,027	74,328	274,355	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		11,480,291	-74,328	11,405,963	0.00	0.00	3.00
4.00	Subtotal other wages & related costs (see inst.)		0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)		0	0	0	0.00	0.00	5.00
6.00	Total (sum of lines 3 thru 5)		11,480,291	-74,328	11,405,963	0.00	0.00	6.00
7.00	Total overhead cost (see instructions)		3,451,101	-74,328	3,376,773	0.00	0.00	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 5/31/2016 8:44 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	-388	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1,216,458	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	15,731	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	8,333	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)	8,875	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	190,640	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	563,261	17.00
18.00	Medicare Taxes - Employers Portion Only	131,730	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	42,316	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,176,956	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	10,014	25.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151318	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 5/31/2016 8:44 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)	0.185391	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,621,693	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,541,263	5.00
6.00	Medicaid charges	28,582,044	6.00
7.00	Medicaid cost (line 1 times line 6)	5,298,854	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)	135,898	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)	222,859	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	1,008,275	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	186,925	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)	135,898	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	29,675	846	30,521	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	5,501	157	5,658	21.00
22.00	Partial payment by patients approved for charity care	0	44	44	22.00
23.00	Cost of charity care (line 21 minus line 22)	5,501	113	5,614	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	5,213,986	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	877,196	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,336,790	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	804,002	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	809,616	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	945,514	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/31/2016 8:44 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	CAP REL COSTS-BLDG & FIXT		722,471	722,471	402,991	1,125,462	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,636,705	1,636,705	339,279	1,975,984	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	95,212	40,465	135,677	1,616,116	1,751,793	4.00
5.01	00570	ADMITTING	0	0	0	1,594,036	1,594,036	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	1,763,655	6,515,012	8,278,667	-3,735,862	4,542,805	5.02
7.00	00700	OPERATION OF PLANT	230,938	1,265,499	1,496,437	5,386	1,501,823	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	91,728	91,728	0	91,728	8.00
9.00	00900	HOUSEKEEPING	229,964	65,076	295,040	0	295,040	9.00
10.00	01000	DIETARY	205,298	169,440	374,738	-244,383	130,355	10.00
11.00	01100	CAFETERIA	0	0	0	243,328	243,328	11.00
13.00	01300	NURSING ADMINISTRATION	297,568	35,516	333,084	-219,270	113,814	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	75,696	329,087	404,783	-219,761	185,022	14.00
15.00	01500	PHARMACY	409,158	949,636	1,358,794	-772,388	586,406	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	143,612	139,592	283,204	79,547	362,751	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,421,277	727,845	2,149,122	-145,140	2,003,982	30.00
31.00	03100	INTENSIVE CARE UNIT	320,843	38,470	359,313	-1,206	358,107	31.00
43.00	04300	NURSERY	0	0	0	132,655	132,655	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	460,915	1,435,249	1,896,164	-507,796	1,388,368	50.00
51.00	05100	RECOVERY ROOM	285,701	39,543	325,244	-1,120	324,124	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	537,439	193,426	730,865	546,308	1,277,173	54.00
54.01	05401	ULTRASOUND	79,852	12,440	92,292	-92,292	0	54.01
56.00	05600	RADIOISOTOPE	81,365	100,595	181,960	-181,960	0	56.00
57.00	05700	CT SCAN	61,457	131,993	193,450	-193,450	0	57.00
58.00	05800	MRI	46,703	94,336	141,039	-141,039	0	58.00
60.00	06000	LABORATORY	633,708	761,492	1,395,200	-49,804	1,345,396	60.00
65.00	06500	RESPIRATORY THERAPY	311,339	55,566	366,905	-2,083	364,822	65.00
66.00	06600	PHYSICAL THERAPY	2,099	493,134	495,233	-1,444	493,789	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	175,587	175,587	0	175,587	67.00
68.00	06800	SPEECH PATHOLOGY	0	14,826	14,826	0	14,826	68.00
69.00	06900	ELECTROCARDIOLOGY	259,749	33,700	293,449	-1,055	292,394	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	202,856	202,856	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	464,848	464,848	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	708,928	708,928	73.00
76.00	03610	SLEEP LAB	75,586	16,191	91,777	-1,268	90,509	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	248,928	55,782	304,710	-3,283	301,427	90.00
91.00	09100	EMERGENCY	3,202,229	891,878	4,094,107	-3,454	4,090,653	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	199,273	147,710	346,983	-3,958	343,025	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,679,564	17,379,990	29,059,554	-185,738	28,873,816	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	754	17,259	18,013	-18,013	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	203,751	203,751	194.01
194.02	07952	SENIOR CIRCLE	0	-964	-964	0	-964	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	11,680,318	17,396,285	29,076,603	0	29,076,603	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/31/2016 8:44 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	256,038	1,381,500		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-331,406	1,644,578		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,573	1,750,220		4.00
5.01	00570	ADMITTING	-89,377	1,504,659		5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	-505,082	4,037,723		5.02
7.00	00700	OPERATION OF PLANT	-13,414	1,488,409		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-53,181	38,547		8.00
9.00	00900	HOUSEKEEPING	0	295,040		9.00
10.00	01000	DIETARY	0	130,355		10.00
11.00	01100	CAFETERIA	-63,639	179,689		11.00
13.00	01300	NURSING ADMINISTRATION	-60	113,754		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	185,022		14.00
15.00	01500	PHARMACY	0	586,406		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-14,177	348,574		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-417,889	1,586,093		30.00
31.00	03100	INTENSIVE CARE UNIT	0	358,107		31.00
43.00	04300	NURSERY	0	132,655		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-453,262	935,106		50.00
51.00	05100	RECOVERY ROOM	0	324,124		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,277,173		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	1,345,396		60.00
65.00	06500	RESPIRATORY THERAPY	0	364,822		65.00
66.00	06600	PHYSICAL THERAPY	0	493,789		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	175,587		67.00
68.00	06800	SPEECH PATHOLOGY	0	14,826		68.00
69.00	06900	ELECTROCARDIOLOGY	-3,078	289,316		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	202,856		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	464,848		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	708,928		73.00
76.00	03610	SLEEP LAB	-5,700	84,809		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	301,427		90.00
91.00	09100	EMERGENCY	0	4,090,653		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	343,025		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,695,800	27,178,016		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NRCC	0	0		194.00
194.01	07951	MARKETING	0	203,751		194.01
194.02	07952	SENIOR CIRCLE	3,464	2,500		194.02
194.03	07953	FREE MEALS	0	0		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-1,692,336	27,384,267		200.00

RECLASSIFICATIONS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/31/2016 8:44 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,617,236		1.00
	TOTALS		0	1,617,236		
	B - RECLASS OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	32,606		1.00
	TOTALS		0	32,606		
	C - RECLASS RENT AND LEASES					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	311,965		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	370		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	TOTALS		0	312,335		
	D - RECLASS OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	74,406		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	328,585		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	27,314		3.00
	TOTALS		0	430,305		
	E - RECLASS MARKETING DEPT					
1.00	MARKETING	194.01	75,081	128,670		1.00
	TOTALS		75,081	128,670		
	F - RECLASS CNO COSTS					
1.00	NURSING ADMINISTRATION	13.00	110,445	0		1.00
	TOTALS		110,445	0		
	G - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	170,250		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	464,848		2.00
	TOTALS		0	635,098		
	H - RECLASS COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	708,928		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	708,928		
	I - RECLASS LABOR AND DELIVERY					
1.00	NURSERY	43.00	112,023	20,632		1.00
	TOTALS		112,023	20,632		
	J - RECLASS NURSING ADMIN COSTS					
1.00	ADMINISTRATIVE AND GENERAL	5.02	218,829	24,143		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	77,142	6,884		2.00
	TOTALS		295,971	31,027		
	K - RECLASS MISC DEPARTMENTS					
1.00	ADMITTING	5.01	465,864	1,128,172		1.00
	TOTALS		465,864	1,128,172		
	L - RECLASS OTHER RADIOLOGY					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	269,377	338,906		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		269,377	338,906		
	M - RECLASS DIETARY COSTS TO CAFETERIA					
1.00	CAFETERIA	11.00	126,284	117,044		1.00
	TOTALS		126,284	117,044		

RECLASSIFICATIONS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/31/2016 8:44 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	N - RECLASS PHYSICIAN PRACTICES COSTS					
1.00	OPERATION OF PLANT	7.00	753	17,630		1.00
	TOTALS		753	17,630		
500.00	Grand Total: Increases		1,455,798	5,518,589		500.00

RECLASSIFICATIONS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/31/2016 8:44 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	1,617,236	0		1.00
	TOTALS		0	1,617,236			
	B - RECLASS OXYGEN COSTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	32,606	0		1.00
	TOTALS		0	32,606			
	C - RECLASS RENT AND LEASES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,120	10		1.00
2.00	ADMINISTRATIVE AND GENERAL	5.02	0	23,061	0		2.00
3.00	OPERATION OF PLANT	7.00	0	12,997	0		3.00
4.00	DIETARY	10.00	0	1,055	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	2,717	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,282	0		6.00
7.00	PHARMACY	15.00	0	63,460	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,479	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	12,485	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	1,206	0		10.00
11.00	OPERATING ROOM	50.00	0	58,571	0		11.00
12.00	RECOVERY ROOM	51.00	0	1,120	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	61,975	0		13.00
14.00	MRI	58.00	0	458	0		14.00
15.00	LABORATORY	60.00	0	49,804	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	2,083	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	1,444	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	1,055	0		18.00
19.00	SLEEP LAB	76.00	0	1,268	0		19.00
20.00	CLINIC	90.00	0	3,283	0		20.00
21.00	EMERGENCY	91.00	0	3,454	0		21.00
22.00	AMBULANCE SERVICES	95.00	0	3,958	0		22.00
	TOTALS		0	312,335			
	D - RECLASS OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	430,305	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	430,305			
	E - RECLASS MARKETING DEPT						
1.00	ADMINISTRATIVE AND GENERAL	5.02	75,081	128,670	0		1.00
	TOTALS		75,081	128,670			
	F - RECLASS CNO COSTS						
1.00	ADMINISTRATIVE AND GENERAL	5.02	110,445	0	0		1.00
	TOTALS		110,445	0			
	G - RECLASS MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	185,873	0		1.00
2.00	OPERATING ROOM	50.00	0	449,225	0		2.00
	TOTALS		0	635,098			
	H - RECLASS COST OF DRUGS/IV SOLUTIONS						
1.00		0.00	0	0	0		1.00
2.00	PHARMACY	15.00	0	708,928	0		2.00
	TOTALS		0	708,928			
	I - RECLASS LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	112,023	20,632	0		1.00
	TOTALS		112,023	20,632			
	J - RECLASS NURSING ADMIN COSTS						
1.00	NURSING ADMINISTRATION	13.00	295,971	31,027	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		295,971	31,027			
	K - RECLASS MISC DEPARTMENTS						
1.00	ADMINISTRATIVE AND GENERAL	5.02	465,864	1,128,172	0		1.00
	TOTALS		465,864	1,128,172			
	L - RECLASS OTHER RADIOLOGY						
1.00	ULTRASOUND	54.01	79,852	12,440	0		1.00
2.00	RADIOISOTOPE	56.00	81,365	100,595	0		2.00
3.00	CT SCAN	57.00	61,457	131,993	0		3.00
4.00	MRI	58.00	46,703	93,878	0		4.00
	TOTALS		269,377	338,906			
	M - RECLASS DIETARY COSTS TO CAFETERIA						
1.00	DIETARY	10.00	126,284	117,044	0		1.00
	TOTALS		126,284	117,044			
	N - RECLASS PHYSICIAN PRACTICES COSTS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	753	17,630	0		1.00
	TOTALS		753	17,630			
500.00	Grand Total: Decreases		1,455,798	5,518,589			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2016 8:44 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	193,225	0	0	0	0	1.00
2.00	Land Improvements	938,654	0	0	0	0	2.00
3.00	Buildings and Fixtures	30,242,257	493,711	0	493,711	0	3.00
4.00	Building Improvements	16,095,396	667,389	0	667,389	21,362	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	2,294,361	147,609	0	147,609	0	7.00
8.00	Subtotal (sum of lines 1-7)	49,763,893	1,308,709	0	1,308,709	21,362	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	49,763,893	1,308,709	0	1,308,709	21,362	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	193,225	0	1.00
2.00	Land Improvements	938,654	0	2.00
3.00	Buildings and Fixtures	30,735,968	0	3.00
4.00	Building Improvements	16,741,423	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	2,441,970	0	7.00
8.00	Subtotal (sum of lines 1-7)	51,051,240	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	51,051,240	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/31/2016 8:44 am

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

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	722,471	722,471		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,636,705	1,636,705		2.00
3.00	Total (sum of lines 1-2)	2,359,176	2,359,176		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2016 8:44 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	261,526	-14,985	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	-380,129	351,385	2.00
3.00	Total (sum of lines 1-2)	0	0	0	-118,603	336,400	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	7,316	74,406	328,585	724,652	1,381,500	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,069	27,314	0	1,644,939	1,644,578	2.00
3.00	Total (sum of lines 1-2)	8,385	101,720	328,585	2,369,591	3,026,078	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/31/2016 8:44 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 - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-30,839	ADMINISTRATIVE AND GENERAL	5.02	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-914,765			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	-204,484			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-63,639	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-14,177	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	-2,091	ADMINISTRATIVE AND GENERAL	5.02	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	261,526	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	6,315	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-377,472	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	RENTAL INCOME	B	-20,896	CAP REL COSTS-BLDG & FIXT	1.00	10	33.00
35.00	TRAINING REVENUE	B	-60	NURSING ADMINISTRATION	13.00	0	35.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/31/2016 8:44 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
36.00	FITNESS REVENUE	B	-440	ADMINISTRATIVE AND GENERAL	5.02	0	36.00
37.00	OTHER MISC REVENUE - HOSPITAL	B	-14,354	ADMINISTRATIVE AND GENERAL	5.02	0	37.00
38.00	PATIENT PHONES BENEFITS COST	A	-1,573	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
40.00	PATIENT PHONES DEPRECIATION COST	A	-6,205	CAP REL COSTS-MVBLE EQUIP	2.00	9	40.00
41.00	PATIENT TV SERVICE COST	A	-15,796	OPERATION OF PLANT	7.00	0	41.00
42.00	PATIENT TV DEPRECIATION	A	-2,767	CAP REL COSTS-MVBLE EQUIP	2.00	9	42.00
43.00	MARKETING EXPENSE	A	-197,927	ADMINISTRATIVE AND GENERAL	5.02	9	43.00
44.00	PENALTIES	A	-37	ADMINISTRATIVE AND GENERAL	5.02	0	44.00
44.01	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-2,320	ADMINISTRATIVE AND GENERAL	5.02	9	44.01
45.00	CHARITABLE CONTRIBUTIONS	A	-3,220	ADMINISTRATIVE AND GENERAL	5.02	0	45.00
45.01	PHYSICIAN RECRUITING	A	-76,239	ADMINISTRATIVE AND GENERAL	5.02	0	45.01
45.02	POB UTILITIES	A	2,382	OPERATION OF PLANT	7.00	0	45.02
45.03	POB PROPERTY TAX	A	787	CAP REL COSTS-BLDG & FIXT	1.00	14	45.03
45.04	OTHER NON-ALLOWABLE COST	A	-1,520	ADMINISTRATIVE AND GENERAL	5.02	0	45.04
45.05	LEGAL FEES	A	-14,269	ADMINISTRATIVE AND GENERAL	5.02	0	45.05
45.06	ELIMINATE NEGATIVE COST CENTER	A	3,464	SENIOR CIRCLE	194.02	0	45.06
45.07	MEALS AND ENTERTAINMENT	A	-1,720	ADMINISTRATIVE AND GENERAL	5.02	0	45.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,692,336				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 5/31/2016 8:44 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	7,316	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	1,069	0	2.00
3.00	5.01	ADMITTING	PASI Operating Costs	114,510	0	3.00
3.01	1.00	CAP REL COSTS-BLDG & FIXT	Pre-Acq Legacy Capital Costs	1,394	0	3.01
3.02	2.00	CAP REL COSTS-MVBLE EQUIP	Pre-Acq Legacy Capital Costs	8,234	0	3.02
3.03	5.02	ADMINISTRATIVE AND GENERAL	Pre-Acq Period Non-Capital A	85,549	0	3.03
3.04	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING AND F	5,911	0	3.04
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	39,420	0	4.00
4.01	5.02	ADMINISTRATIVE AND GENERAL	NON-CAPITAL HOME OFFICE COST	566,116	0	4.01
4.02	5.02	ADMINISTRATIVE AND GENERAL	MALPRACTICE ALLOCATIONS (PER	124,859	151,108	4.02
4.03	5.02	ADMINISTRATIVE AND GENERAL	CIG LEASED EQUIPMENT (PER EX	9,537	14,258	4.03
4.05	8.00	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICES (P	107,289	160,470	4.05
4.06	5.02	ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	0	277,218	4.06
4.07	5.02	ADMINISTRATIVE AND GENERAL	401K FEES	0	1,349	4.07
4.08	5.02	ADMINISTRATIVE AND GENERAL	AUDIT FEES	0	19,027	4.08
4.09	5.02	ADMINISTRATIVE AND GENERAL	CORPORATE OVERHEAD FEES	0	428,691	4.09
4.10	5.02	ADMINISTRATIVE AND GENERAL	PPSI FEES	0	19,680	4.10
4.11	5.01	ADMITTING	PASI COLLECTION FEES	0	165,912	4.11
4.12	5.01	ADMITTING	EBOS FEES	0	6,829	4.12
4.13	5.01	ADMITTING	PASI LIEN UNIT COLLECTION FE	0	31,146	4.13
4.14	0.00			0	0	4.14
4.15	0.00			0	0	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	0.00			0	0	4.18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,071,204	1,275,688	5.00

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

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

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

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

6.00	B		0.00	COMMUNITY HEALTH SYTEMS	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00	B		0.00	HOSPITAL LAUNDRY SERVICE	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 151318	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-1 Date/Time Prepared: 5/31/2016 8:44 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	7,316	11		1.00
2.00	1,069	11		2.00
3.00	114,510	0		3.00
3.01	1,394	14		3.01
3.02	8,234	14		3.02
3.03	85,549	0		3.03
3.04	5,911	10		3.04
4.00	39,420	10		4.00
4.01	566,116	0		4.01
4.02	-26,249	0		4.02
4.03	-4,721	0		4.03
4.05	-53,181	0		4.05
4.06	-277,218	0		4.06
4.07	-1,349	0		4.07
4.08	-19,027	0		4.08
4.09	-428,691	0		4.09
4.10	-19,680	0		4.10
4.11	-165,912	0		4.11
4.12	-6,829	0		4.12
4.13	-31,146	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
5.00	-204,484			5.00

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

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

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

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

6.00	HOSPITAL MANAGEMENT		6.00
7.00	DEBT COLLECTION		7.00
8.00	LAUNDRY SERVICE		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2016 8:44 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.02	ADMINISTRATIVE AND GENERAL	34,836	34,836	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	417,889	417,889	0	0	0	2.00
3.00	50.00	OPERATING ROOM	453,262	453,262	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	3,078	3,078	0	0	0	4.00
5.00	76.00	SLEEP LAB	5,700	5,700	0	0	0	5.00
6.00	91.00	EMERGENCY	2,338,567	0	2,338,567	0	0	6.00
7.00	95.00	AMBULANCE SERVICES	1,284	0	1,284	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,254,616	914,765	2,339,851		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.02	ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	76.00	SLEEP LAB	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.02	ADMINISTRATIVE AND GENERAL	0	0	0	34,836		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	417,889		2.00
3.00	50.00	OPERATING ROOM	0	0	0	453,262		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	3,078		4.00
5.00	76.00	SLEEP LAB	0	0	0	5,700		5.00
6.00	91.00	EMERGENCY	0	0	0	0		6.00
7.00	95.00	AMBULANCE SERVICES	0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	914,765		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2016 8:44 am

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					5.19	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	3,739.00	3,166.00	3,682.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.03	57.04	38.02	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.02	39.02	28.52			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					291,754	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					180,589	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					472,343	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					139,990	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					612,333	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					612,333	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2016 8:44 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.03	57.04	38.02	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	612,333	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	612,333	63.00
64.00	Total cost of outside supplier services (from your records)	0	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151318	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2016 8:44 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		0	1.00
2.00	Line 1 multiplied by 15 hours per week		0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,123.00	293.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.96	54.06	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.98	36.98	27.03			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	157,017	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	15,840	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	172,857	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	172,857	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	172,857	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151318	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2016 8:44 am

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.96	54.06	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		172,857	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		172,857	63.00
64.00	Total cost of outside supplier services (from your records)		0	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		0	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151318	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2016 8:44 am
		Speech Pathology	Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.19	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	209.00	3.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	71.08	71.08	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	35.54	35.54	35.54			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					14,856	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					213	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					15,069	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					15,069	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					71.08	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					55,442	22.00
23.00	Total salary equivalency (see instructions)					55,442	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2016 8:44 am

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	71.08	71.08	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	55,442		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	55,442		63.00
64.00	Total cost of outside supplier services (from your records)	0		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/31/2016 8:44 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,381,500	1,381,500				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,644,578		1,644,578			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,750,220	9,749	11,653	1,771,622		4.00
5.01	00570	ADMITTING	1,504,659	14,833	17,731	71,241	1,608,464	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	4,037,723	70,335	84,072	203,554	0	5.02
7.00	00700	OPERATION OF PLANT	1,488,409	408,816	488,666	35,431	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	38,547	16,050	19,185	0	0	8.00
9.00	00900	HOUSEKEEPING	295,040	13,288	15,883	35,167	0	9.00
10.00	01000	DIETARY	130,355	33,548	40,101	12,083	0	10.00
11.00	01100	CAFETERIA	179,689	21,547	25,756	19,312	0	11.00
13.00	01300	NURSING ADMINISTRATION	113,754	6,266	7,490	17,134	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	185,022	32,884	39,306	11,576	0	14.00
15.00	01500	PHARMACY	586,406	15,351	18,349	62,569	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	348,574	27,744	33,162	33,758	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,586,093	230,285	275,262	200,214	80,245	30.00
31.00	03100	INTENSIVE CARE UNIT	358,107	26,688	31,900	49,064	10,665	31.00
43.00	04300	NURSERY	132,655	5,280	6,311	17,131	4,893	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	935,106	105,799	126,463	70,484	197,539	50.00
51.00	05100	RECOVERY ROOM	324,124	7,616	9,104	43,690	34,496	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,277,173	74,412	88,945	123,380	344,416	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,345,396	29,751	35,561	96,908	234,343	60.00
65.00	06500	RESPIRATORY THERAPY	364,822	12,770	15,264	47,611	21,399	65.00
66.00	06600	PHYSICAL THERAPY	493,789	17,526	20,949	321	31,798	66.00
67.00	06700	OCCUPATIONAL THERAPY	175,587	5,735	6,855	0	11,310	67.00
68.00	06800	SPEECH PATHOLOGY	14,826	231	276	0	728	68.00
69.00	06900	ELECTROCARDIOLOGY	289,316	8,665	10,357	39,721	55,154	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	202,856	0	0	0	55,108	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	464,848	0	0	0	40,081	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	708,928	0	0	0	174,916	73.00
76.00	03610	SLEEP LAB	84,809	12,372	14,788	11,559	9,286	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	301,427	8,043	9,613	38,067	6,750	90.00
91.00	09100	EMERGENCY	4,090,653	51,249	61,259	489,692	227,167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	343,025	20,638	24,669	30,473	68,170	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,178,016	1,287,471	1,538,930	1,760,140	1,608,464	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,644	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	88,385	105,648	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	203,751	0	0	11,482	0	194.01
194.02	07952	SENIOR CIRCLE	2,500	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
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)	27,384,267	1,381,500	1,644,578	1,771,622	1,608,464	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/31/2016 8:44 am

		Cost Center Description	Subtotal	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	4,395,684	4,395,684				5.02
7.00	00700	OPERATION OF PLANT	2,421,322	462,986	2,884,308			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,782	14,108	52,741	140,631		8.00
9.00	00900	HOUSEKEEPING	359,378	68,717	43,663	0	471,758	9.00
10.00	01000	DIETARY	216,087	41,318	110,238	0	18,654	10.00
11.00	01100	CAFETERIA	246,304	47,096	70,804	0	11,981	11.00
13.00	01300	NURSING ADMINISTRATION	144,644	27,658	20,591	0	3,484	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	268,788	51,395	108,055	0	18,285	14.00
15.00	01500	PHARMACY	682,675	130,536	50,443	0	8,536	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	443,238	84,752	91,164	0	15,426	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,372,099	453,574	756,709	55,828	128,048	30.00
31.00	03100	INTENSIVE CARE UNIT	476,424	91,098	87,694	3,423	14,839	31.00
43.00	04300	NURSERY	166,270	31,793	17,350	0	2,936	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,435,391	274,464	347,652	23,336	58,828	50.00
51.00	05100	RECOVERY ROOM	419,030	80,124	25,026	0	4,235	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,908,326	364,895	244,515	15,891	41,376	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,741,959	333,083	97,760	230	16,543	60.00
65.00	06500	RESPIRATORY THERAPY	461,866	88,314	41,963	0	7,101	65.00
66.00	06600	PHYSICAL THERAPY	564,383	107,917	57,590	0	9,745	66.00
67.00	06700	OCCUPATIONAL THERAPY	199,487	38,144	18,844	0	3,189	67.00
68.00	06800	SPEECH PATHOLOGY	16,061	3,071	758	0	128	68.00
69.00	06900	ELECTROCARDIOLOGY	403,213	77,099	28,473	0	4,818	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	257,964	49,326	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	504,929	96,548	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	883,844	169,002	0	0	0	73.00
76.00	03610	SLEEP LAB	132,814	25,396	40,653	3,521	6,879	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	363,900	69,582	26,428	0	4,472	90.00
91.00	09100	EMERGENCY	4,920,020	940,760	168,403	38,402	28,496	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	486,975	93,115	67,816	0	11,476	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,966,857	4,315,871	2,575,333	140,631	419,475	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,644	1,079	18,545	0	3,138	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	194,033	37,101	290,430	0	49,145	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	215,233	41,155	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	2,500	478	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
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)	27,384,267	4,395,684	2,884,308	140,631	471,758	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/31/2016 8:44 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	386,297					10.00
11.00	01100	CAFETERIA	0	376,185				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,037	198,414			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,241	0	452,764		14.00
15.00	01500	PHARMACY	0	13,109	0	9,983	895,282	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,414	0	598	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	257,275	64,108	31,969	26,387	0	30.00
31.00	03100	INTENSIVE CARE UNIT	33,485	13,239	8,926	2,920	0	31.00
43.00	04300	NURSERY	0	4,961	7,574	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	21,804	12,824	87,356	0	50.00
51.00	05100	RECOVERY ROOM	0	11,673	7,949	3,638	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	39,587	22,447	22,236	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	42,617	17,631	91,791	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	15,093	0	8,399	0	65.00
66.00	06600	PHYSICAL THERAPY	0	157	0	1,365	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,522	0	1,060	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	49,204	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	110,808	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	895,282	73.00
76.00	03610	SLEEP LAB	0	3,447	0	720	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	9,740	0	7,223	0	90.00
91.00	09100	EMERGENCY	10,709	78,184	89,094	17,369	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	15,511	0	11,411	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	301,469	373,444	198,414	452,468	895,282	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	104	0	64	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	2,637	0	232	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	84,828	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	386,297	376,185	198,414	452,764	895,282	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/31/2016 8:44 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	649,592					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,407	4,178,404	0	4,178,404		30.00
31.00	03100	INTENSIVE CARE UNIT	4,307	736,355	0	736,355		31.00
43.00	04300	NURSERY	1,976	232,860	0	232,860		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	79,776	2,341,431	0	2,341,431		50.00
51.00	05100	RECOVERY ROOM	13,931	565,606	0	565,606		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,109	2,798,382	0	2,798,382		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	94,639	2,436,253	0	2,436,253		60.00
65.00	06500	RESPIRATORY THERAPY	8,642	631,378	0	631,378		65.00
66.00	06600	PHYSICAL THERAPY	12,842	753,999	0	753,999		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,568	264,232	0	264,232		67.00
68.00	06800	SPEECH PATHOLOGY	294	20,312	0	20,312		68.00
69.00	06900	ELECTROCARDIOLOGY	22,274	554,459	0	554,459		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,255	378,749	0	378,749		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,186	728,471	0	728,471		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,639	2,018,767	0	2,018,767		73.00
76.00	03610	SLEEP LAB	3,750	217,180	0	217,180		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,726	484,071	0	484,071		90.00
91.00	09100	EMERGENCY	91,741	6,383,178	0	6,383,178		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	27,530	713,834	0	713,834		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	649,592	26,437,921	0	26,437,921		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28,406	0	28,406		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	570,877	0	570,877		192.00
194.00	07950	OTHER NRCC	0	0	0	0		194.00
194.01	07951	MARKETING	0	259,257	0	259,257		194.01
194.02	07952	SENIOR CIRCLE	0	2,978	0	2,978		194.02
194.03	07953	FREE MEALS	0	84,828	0	84,828		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	649,592	27,384,267	0	27,384,267		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/31/2016 8:44 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,749	11,653	21,402	21,402	4.00
5.01	00570	ADMITTING	0	14,833	17,731	32,564	860	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	0	70,335	84,072	154,407	2,459	5.02
7.00	00700	OPERATION OF PLANT	0	408,816	488,666	897,482	428	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,050	19,185	35,235	0	8.00
9.00	00900	HOUSEKEEPING	0	13,288	15,883	29,171	425	9.00
10.00	01000	DIETARY	0	33,548	40,101	73,649	146	10.00
11.00	01100	CAFETERIA	0	21,547	25,756	47,303	233	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,266	7,490	13,756	207	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	32,884	39,306	72,190	140	14.00
15.00	01500	PHARMACY	0	15,351	18,349	33,700	756	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,744	33,162	60,906	408	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	230,285	275,262	505,547	2,418	30.00
31.00	03100	INTENSIVE CARE UNIT	0	26,688	31,900	58,588	593	31.00
43.00	04300	NURSERY	0	5,280	6,311	11,591	207	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	105,799	126,463	232,262	851	50.00
51.00	05100	RECOVERY ROOM	0	7,616	9,104	16,720	528	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	74,412	88,945	163,357	1,490	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	29,751	35,561	65,312	1,170	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,770	15,264	28,034	575	65.00
66.00	06600	PHYSICAL THERAPY	0	17,526	20,949	38,475	4	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,735	6,855	12,590	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	231	276	507	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,665	10,357	19,022	480	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	12,372	14,788	27,160	140	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	8,043	9,613	17,656	460	90.00
91.00	09100	EMERGENCY	0	51,249	61,259	112,508	5,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	20,638	24,669	45,307	368	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,287,471	1,538,930	2,826,401	21,263	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,644	0	5,644	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	88,385	105,648	194,033	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	139	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,381,500	1,644,578	3,026,078	21,402	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/31/2016 8:44 am

		Cost Center Description	ADMITTING	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	33,424					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	0	156,866				5.02
7.00	00700	OPERATION OF PLANT	0	16,523	914,433			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	503	16,721	52,459		8.00
9.00	00900	HOUSEKEEPING	0	2,452	13,843	0	45,891	9.00
10.00	01000	DIETARY	0	1,475	34,950	0	1,815	10.00
11.00	01100	CAFETERIA	0	1,681	22,447	0	1,165	11.00
13.00	01300	NURSING ADMINISTRATION	0	987	6,528	0	339	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,834	34,258	0	1,779	14.00
15.00	01500	PHARMACY	0	4,659	15,992	0	830	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,025	28,903	0	1,501	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,665	16,187	239,904	20,824	12,455	30.00
31.00	03100	INTENSIVE CARE UNIT	221	3,251	27,802	1,277	1,444	31.00
43.00	04300	NURSERY	102	1,135	5,501	0	286	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,098	9,795	110,219	8,705	5,723	50.00
51.00	05100	RECOVERY ROOM	716	2,859	7,934	0	412	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,198	13,022	77,520	5,928	4,025	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,862	11,887	30,994	86	1,609	60.00
65.00	06500	RESPIRATORY THERAPY	444	3,152	13,304	0	691	65.00
66.00	06600	PHYSICAL THERAPY	660	3,851	18,258	0	948	66.00
67.00	06700	OCCUPATIONAL THERAPY	235	1,361	5,974	0	310	67.00
68.00	06800	SPEECH PATHOLOGY	15	110	240	0	12	68.00
69.00	06900	ELECTROCARDIOLOGY	1,144	2,752	9,027	0	469	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,143	1,760	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	832	3,446	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,629	6,031	0	0	0	73.00
76.00	03610	SLEEP LAB	193	906	12,888	1,314	669	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	140	2,483	8,379	0	435	90.00
91.00	09100	EMERGENCY	4,713	33,567	53,390	14,325	2,772	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,414	3,323	21,500	0	1,116	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	33,424	154,017	816,476	52,459	40,805	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	39	5,880	0	305	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,324	92,077	0	4,781	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,469	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	17	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	33,424	156,866	914,433	52,459	45,891	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/31/2016 8:44 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	112,035					10.00
11.00	01100	CAFETERIA	0	72,829				11.00
13.00	01300	NURSING ADMINISTRATION	0	394	22,211			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,208	0	111,409		14.00
15.00	01500	PHARMACY	0	2,538	0	2,456	60,931	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,791	0	147	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,616	12,411	3,578	6,493	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,711	2,563	999	718	0	31.00
43.00	04300	NURSERY	0	961	848	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,221	1,435	21,495	0	50.00
51.00	05100	RECOVERY ROOM	0	2,260	890	895	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,664	2,512	5,471	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	8,251	1,973	22,586	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,922	0	2,067	0	65.00
66.00	06600	PHYSICAL THERAPY	0	30	0	336	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,392	0	261	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,107	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	27,268	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	60,931	73.00
76.00	03610	SLEEP LAB	0	667	0	177	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,886	0	1,777	0	90.00
91.00	09100	EMERGENCY	3,106	15,136	9,976	4,274	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,003	0	2,808	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	87,433	72,298	22,211	111,336	60,931	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20	0	16	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	511	0	57	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	24,602	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	112,035	72,829	22,211	111,409	60,931	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/31/2016 8:44 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	97,681					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,873	900,971	0	900,971		30.00
31.00	03100	INTENSIVE CARE UNIT	648	107,815	0	107,815		31.00
43.00	04300	NURSERY	297	20,928	0	20,928		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,997	410,801	0	410,801		50.00
51.00	05100	RECOVERY ROOM	2,095	35,309	0	35,309		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,913	309,100	0	309,100		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	14,232	162,962	0	162,962		60.00
65.00	06500	RESPIRATORY THERAPY	1,300	52,489	0	52,489		65.00
66.00	06600	PHYSICAL THERAPY	1,931	64,493	0	64,493		66.00
67.00	06700	OCCUPATIONAL THERAPY	687	21,157	0	21,157		67.00
68.00	06800	SPEECH PATHOLOGY	44	928	0	928		68.00
69.00	06900	ELECTROCARDIOLOGY	3,350	39,897	0	39,897		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,347	18,357	0	18,357		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,434	33,980	0	33,980		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,623	81,214	0	81,214		73.00
76.00	03610	SLEEP LAB	564	44,678	0	44,678		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	410	33,626	0	33,626		90.00
91.00	09100	EMERGENCY	13,796	273,480	0	273,480		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,140	82,979	0	82,979		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	97,681	2,695,164	0	2,695,164		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,868	0	11,868		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	292,251	0	292,251		192.00
194.00	07950	OTHER NRCC	0	0	0	0		194.00
194.01	07951	MARKETING	0	2,176	0	2,176		194.01
194.02	07952	SENIOR CIRCLE	0	17	0	17		194.02
194.03	07953	FREE MEALS	0	24,602	0	24,602		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	97,681	3,026,078	0	3,026,078		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/31/2016 8:44 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	197,538					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		196,731				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,394	1,394	11,585,106			4.00
5.01	00570	ADMITTING	2,121	2,121	465,864	142,606,323		5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	10,057	10,057	1,331,094	0	-4,395,684	5.02
7.00	00700	OPERATION OF PLANT	58,456	58,456	231,691	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,295	2,295	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,900	1,900	229,964	0	0	9.00
10.00	01000	DIETARY	4,797	4,797	79,014	0	0	10.00
11.00	01100	CAFETERIA	3,081	3,081	126,284	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	896	896	112,042	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,702	4,702	75,696	0	0	14.00
15.00	01500	PHARMACY	2,195	2,195	409,158	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,967	3,967	220,754	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,928	32,928	1,309,254	7,114,511	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,816	3,816	320,843	945,524	0	31.00
43.00	04300	NURSERY	755	755	112,023	433,853	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,128	15,128	460,915	17,513,871	0	50.00
51.00	05100	RECOVERY ROOM	1,089	1,089	285,701	3,058,450	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,640	10,640	806,816	30,535,234	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,254	4,254	633,708	20,776,974	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,826	1,826	311,339	1,897,283	0	65.00
66.00	06600	PHYSICAL THERAPY	2,506	2,506	2,099	2,819,249	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	820	820	0	1,002,790	0	67.00
68.00	06800	SPEECH PATHOLOGY	33	33	0	64,557	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,239	1,239	259,749	4,889,997	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,885,926	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,553,562	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,508,092	0	73.00
76.00	03610	SLEEP LAB	1,769	1,769	75,586	823,303	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,150	1,150	248,928	598,468	0	90.00
91.00	09100	EMERGENCY	7,328	7,328	3,202,229	20,140,685	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,951	2,951	199,273	6,043,994	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	184,093	184,093	11,510,024	142,606,323	-4,395,684	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	807	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,638	12,638	1	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	75,081	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,381,500	1,644,578	1,771,622	1,608,464		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.993591	8.359526	0.152922	0.011279		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			21,402	33,424		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001847	0.000234		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/31/2016 8:44 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERV)	
			5.02	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	22,988,583					5.02
7.00	00700	OPERATION OF PLANT	2,421,322	125,510				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,782	2,295	170,049			8.00
9.00	00900	HOUSEKEEPING	359,378	1,900	0	121,315		9.00
10.00	01000	DIETARY	216,087	4,797	0	4,797	15,078	10.00
11.00	01100	CAFETERIA	246,304	3,081	0	3,081	0	11.00
13.00	01300	NURSING ADMINISTRATION	144,644	896	0	896	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	268,788	4,702	0	4,702	0	14.00
15.00	01500	PHARMACY	682,675	2,195	0	2,195	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	443,238	3,967	0	3,967	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,372,099	32,928	67,506	32,928	10,042	30.00
31.00	03100	INTENSIVE CARE UNIT	476,424	3,816	4,139	3,816	1,307	31.00
43.00	04300	NURSERY	166,270	755	0	755	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,435,391	15,128	28,218	15,128	0	50.00
51.00	05100	RECOVERY ROOM	419,030	1,089	0	1,089	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,908,326	10,640	19,215	10,640	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,741,959	4,254	278	4,254	0	60.00
65.00	06500	RESPIRATORY THERAPY	461,866	1,826	0	1,826	0	65.00
66.00	06600	PHYSICAL THERAPY	564,383	2,506	0	2,506	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	199,487	820	0	820	0	67.00
68.00	06800	SPEECH PATHOLOGY	16,061	33	0	33	0	68.00
69.00	06900	ELECTROCARDIOLOGY	403,213	1,239	0	1,239	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	257,964	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	504,929	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	883,844	0	0	0	0	73.00
76.00	03610	SLEEP LAB	132,814	1,769	4,258	1,769	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	363,900	1,150	0	1,150	0	90.00
91.00	09100	EMERGENCY	4,920,020	7,328	46,435	7,328	418	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	486,975	2,951	0	2,951	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,571,173	112,065	170,049	107,870	11,767	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,644	807	0	807	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	194,033	12,638	0	12,638	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	215,233	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	2,500	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	3,311	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,395,684	2,884,308	140,631	471,758	386,297	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.191212	22.980703	0.827003	3.888703	25.619910	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	156,866	914,433	52,459	45,891	112,035	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006824	7.285738	0.308493	0.378280	7.430362	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/31/2016 8:44 am

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQ U)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	14,406					11.00
13.00	01300	NURSING ADMINISTRATION	78	7,131,489				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	239	0	1,903,022			14.00
15.00	01500	PHARMACY	502	0	41,959	708,928		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	552	0	2,514	0	142,606,323	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,455	1,149,061	110,910	0	7,114,511	30.00
31.00	03100	INTENSIVE CARE UNIT	507	320,843	12,272	0	945,524	31.00
43.00	04300	NURSERY	190	272,216	0	0	433,853	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	835	460,915	367,168	0	17,513,871	50.00
51.00	05100	RECOVERY ROOM	447	285,701	15,292	0	3,058,450	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,516	806,816	93,461	0	30,535,234	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,632	633,708	385,809	0	20,776,974	60.00
65.00	06500	RESPIRATORY THERAPY	578	0	35,303	0	1,897,283	65.00
66.00	06600	PHYSICAL THERAPY	6	0	5,739	0	2,819,249	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,002,790	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	64,557	68.00
69.00	06900	ELECTROCARDIOLOGY	671	0	4,455	0	4,889,997	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	206,810	0	4,885,926	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	465,737	0	3,553,562	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	708,928	15,508,092	73.00
76.00	03610	SLEEP LAB	132	0	3,026	0	823,303	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	373	0	30,359	0	598,468	90.00
91.00	09100	EMERGENCY	2,994	3,202,229	73,005	0	20,140,685	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	594	0	47,961	0	6,043,994	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,301	7,131,489	1,901,780	708,928	142,606,323	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4	0	267	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	101	0	975	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	376,185	198,414	452,764	895,282	649,592	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.113078	0.027822	0.237918	1.262867	0.004555	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	72,829	22,211	111,409	60,931	97,681	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.055463	0.003114	0.058543	0.085948	0.000685	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/31/2016 8:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,178,404		4,178,404	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	736,355		736,355	0	0	31.00
43.00	04300	NURSERY	232,860		232,860	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,341,431		2,341,431	0	0	50.00
51.00	05100	RECOVERY ROOM	565,606		565,606	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,798,382		2,798,382	0	0	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	2,436,253		2,436,253	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	631,378	0	631,378	0	0	65.00
66.00	06600	PHYSICAL THERAPY	753,999	0	753,999	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	264,232	0	264,232	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	20,312	0	20,312	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	554,459		554,459	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	378,749		378,749	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	728,471		728,471	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,018,767		2,018,767	0	0	73.00
76.00	03610	SLEEP LAB	217,180		217,180	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	484,071		484,071	0	0	90.00
91.00	09100	EMERGENCY	6,383,178		6,383,178	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	780,413		780,413		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	713,834		713,834	0	0	95.00
200.00		Subtotal (see instructions)	27,218,334	0	27,218,334	0	0	200.00
201.00		Less Observation Beds	780,413		780,413		0	201.00
202.00		Total (see instructions)	26,437,921	0	26,437,921	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/31/2016 8:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,313,407		5,313,407			30.00
31.00	03100	INTENSIVE CARE UNIT	945,524		945,524			31.00
43.00	04300	NURSERY	433,853		433,853			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,887,560	12,626,311	17,513,871	0.133690	0.000000	50.00
51.00	05100	RECOVERY ROOM	641,019	2,417,431	3,058,450	0.184932	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,258,481	26,276,753	30,535,234	0.091644	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	4,507,711	16,269,263	20,776,974	0.117257	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,408,551	488,732	1,897,283	0.332780	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	509,510	2,309,739	2,819,249	0.267447	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	428,097	574,693	1,002,790	0.263497	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	18,532	46,025	64,557	0.314637	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,290,966	3,599,031	4,889,997	0.113386	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,105,810	2,780,116	4,885,926	0.077518	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,360,175	1,193,387	3,553,562	0.204997	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,641,310	7,866,782	15,508,092	0.130175	0.000000	73.00
76.00	03610	SLEEP LAB	14,520	808,783	823,303	0.263791	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,548	587,920	598,468	0.808850	0.000000	90.00
91.00	09100	EMERGENCY	2,028,099	18,112,586	20,140,685	0.316930	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	388,691	1,412,413	1,801,104	0.433297	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	6,043,994	6,043,994	0.118106	0.000000	95.00
200.00		Subtotal (see instructions)	39,192,364	103,413,959	142,606,323			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	39,192,364	103,413,959	142,606,323			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/31/2016 8:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03610	SLEEP LAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/31/2016 8:44 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	4,178,404		4,178,404	0	4,178,404	30.00
31.00	03100	INTENSIVE CARE UNIT	736,355		736,355	0	736,355	31.00
43.00	04300	NURSERY	232,860		232,860	0	232,860	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,341,431		2,341,431	0	2,341,431	50.00
51.00	05100	RECOVERY ROOM	565,606		565,606	0	565,606	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,798,382		2,798,382	0	2,798,382	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	2,436,253		2,436,253	0	2,436,253	60.00
65.00	06500	RESPIRATORY THERAPY	631,378	0	631,378	0	631,378	65.00
66.00	06600	PHYSICAL THERAPY	753,999	0	753,999	0	753,999	66.00
67.00	06700	OCCUPATIONAL THERAPY	264,232	0	264,232	0	264,232	67.00
68.00	06800	SPEECH PATHOLOGY	20,312	0	20,312	0	20,312	68.00
69.00	06900	ELECTROCARDIOLOGY	554,459		554,459	0	554,459	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	378,749		378,749	0	378,749	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	728,471		728,471	0	728,471	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,018,767		2,018,767	0	2,018,767	73.00
76.00	03610	SLEEP LAB	217,180		217,180	0	217,180	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	484,071		484,071	0	484,071	90.00
91.00	09100	EMERGENCY	6,383,178		6,383,178	0	6,383,178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	780,413		780,413		780,413	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	713,834		713,834	0	713,834	95.00
200.00		Subtotal (see instructions)	27,218,334	0	27,218,334	0	27,218,334	200.00
201.00		Less Observation Beds	780,413		780,413		780,413	201.00
202.00		Total (see instructions)	26,437,921	0	26,437,921	0	26,437,921	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/31/2016 8:44 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	5,313,407		5,313,407			30.00
31.00	03100	INTENSIVE CARE UNIT	945,524		945,524			31.00
43.00	04300	NURSERY	433,853		433,853			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,887,560	12,626,311	17,513,871	0.133690	0.000000	50.00
51.00	05100	RECOVERY ROOM	641,019	2,417,431	3,058,450	0.184932	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,258,481	26,276,753	30,535,234	0.091644	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	4,507,711	16,269,263	20,776,974	0.117257	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,408,551	488,732	1,897,283	0.332780	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	509,510	2,309,739	2,819,249	0.267447	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	428,097	574,693	1,002,790	0.263497	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	18,532	46,025	64,557	0.314637	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,290,966	3,599,031	4,889,997	0.113386	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,105,810	2,780,116	4,885,926	0.077518	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,360,175	1,193,387	3,553,562	0.204997	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,641,310	7,866,782	15,508,092	0.130175	0.000000	73.00
76.00	03610	SLEEP LAB	14,520	808,783	823,303	0.263791	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,548	587,920	598,468	0.808850	0.000000	90.00
91.00	09100	EMERGENCY	2,028,099	18,112,586	20,140,685	0.316930	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	388,691	1,412,413	1,801,104	0.433297	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	6,043,994	6,043,994	0.118106	0.000000	95.00
200.00		Subtotal (see instructions)	39,192,364	103,413,959	142,606,323			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	39,192,364	103,413,959	142,606,323			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/31/2016 8:44 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.133690		50.00
51.00	05100	RECOVERY ROOM	0.184932		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091644		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.117257		60.00
65.00	06500	RESPIRATORY THERAPY	0.332780		65.00
66.00	06600	PHYSICAL THERAPY	0.267447		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.263497		67.00
68.00	06800	SPEECH PATHOLOGY	0.314637		68.00
69.00	06900	ELECTROCARDIOLOGY	0.113386		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.077518		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.204997		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130175		73.00
76.00	03610	SLEEP LAB	0.263791		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.808850		90.00
91.00	09100	EMERGENCY	0.316930		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.433297		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.118106		95.00
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: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II Date/Time Prepared: 5/31/2016 8:44 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,341,431	410,801	1,930,630	0	0	50.00
51.00	05100	RECOVERY ROOM	565,606	35,309	530,297	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,798,382	309,100	2,489,282	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,436,253	162,962	2,273,291	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	631,378	52,489	578,889	0	0	65.00
66.00	06600	PHYSICAL THERAPY	753,999	64,493	689,506	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	264,232	21,157	243,075	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	20,312	928	19,384	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	554,459	39,897	514,562	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	378,749	18,357	360,392	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	728,471	33,980	694,491	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,018,767	81,214	1,937,553	0	0	73.00
76.00	03610	SLEEP LAB	217,180	44,678	172,502	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	484,071	33,626	450,445	0	0	90.00
91.00	09100	EMERGENCY	6,383,178	273,480	6,109,698	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	780,413	175,769	604,644	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	713,834	82,979	630,855	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	22,070,715	1,841,219	20,229,496	0	0	200.00
201.00		Less Observation Beds	780,413	175,769	604,644	0	0	201.00
202.00		Total (line 200 minus line 201)	21,290,302	1,665,450	19,624,852	0	0	202.00

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

Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II Date/Time Prepared: 5/31/2016 8:44 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	2,341,431	17,513,871	0.133690		50.00
51.00	05100	RECOVERY ROOM	565,606	3,058,450	0.184932		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,798,382	30,535,234	0.091644		54.00
54.01	05401	ULTRASOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	0	0	0.000000		58.00
60.00	06000	LABORATORY	2,436,253	20,776,974	0.117257		60.00
65.00	06500	RESPIRATORY THERAPY	631,378	1,897,283	0.332780		65.00
66.00	06600	PHYSICAL THERAPY	753,999	2,819,249	0.267447		66.00
67.00	06700	OCCUPATIONAL THERAPY	264,232	1,002,790	0.263497		67.00
68.00	06800	SPEECH PATHOLOGY	20,312	64,557	0.314637		68.00
69.00	06900	ELECTROCARDIOLOGY	554,459	4,889,997	0.113386		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	378,749	4,885,926	0.077518		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	728,471	3,553,562	0.204997		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,018,767	15,508,092	0.130175		73.00
76.00	03610	SLEEP LAB	217,180	823,303	0.263791		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	484,071	598,468	0.808850		90.00
91.00	09100	EMERGENCY	6,383,178	20,140,685	0.316930		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	780,413	1,801,104	0.433297		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	713,834	6,043,994	0.118106		95.00
200.00		Subtotal (sum of lines 50 thru 199)	22,070,715	135,913,539			200.00
201.00		Less Observation Beds	780,413	0			201.00
202.00		Total (line 200 minus line 201)	21,290,302	135,913,539			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/31/2016 8:44 am

Title XVIII | Hospital | Cost

		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	410,801	17,513,871	0.023456	1,367,757	32,082	50.00
51.00	05100	RECOVERY ROOM	35,309	3,058,450	0.011545	188,028	2,171	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	309,100	30,535,234	0.010123	1,576,820	15,962	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	162,962	20,776,974	0.007843	1,748,590	13,714	60.00
65.00	06500	RESPIRATORY THERAPY	52,489	1,897,283	0.027665	824,437	22,808	65.00
66.00	06600	PHYSICAL THERAPY	64,493	2,819,249	0.022876	248,023	5,674	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,157	1,002,790	0.021098	246,570	5,202	67.00
68.00	06800	SPEECH PATHOLOGY	928	64,557	0.014375	14,453	208	68.00
69.00	06900	ELECTROCARDIOLOGY	39,897	4,889,997	0.008159	666,670	5,439	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,357	4,885,926	0.003757	936,742	3,519	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,980	3,553,562	0.009562	1,244,618	11,901	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	81,214	15,508,092	0.005237	3,836,059	20,089	73.00
76.00	03610	SLEEP LAB	44,678	823,303	0.054267	10,863	590	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	33,626	598,468	0.056187	0	0	90.00
91.00	09100	EMERGENCY	273,480	20,140,685	0.013578	2,136	29	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	175,769	1,801,104	0.097590	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,758,240	129,869,545		12,911,766	139,388	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/31/2016 8:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/31/2016 8:44 am

Title XVIII | Hospital | Cost

		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	17,513,871	0.000000	0.000000	1,367,757	50.00
51.00	05100	RECOVERY ROOM	0	3,058,450	0.000000	0.000000	188,028	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,535,234	0.000000	0.000000	1,576,820	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	20,776,974	0.000000	0.000000	1,748,590	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,897,283	0.000000	0.000000	824,437	65.00
66.00	06600	PHYSICAL THERAPY	0	2,819,249	0.000000	0.000000	248,023	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,002,790	0.000000	0.000000	246,570	67.00
68.00	06800	SPEECH PATHOLOGY	0	64,557	0.000000	0.000000	14,453	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,889,997	0.000000	0.000000	666,670	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,885,926	0.000000	0.000000	936,742	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,553,562	0.000000	0.000000	1,244,618	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,508,092	0.000000	0.000000	3,836,059	73.00
76.00	03610	SLEEP LAB	0	823,303	0.000000	0.000000	10,863	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	598,468	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	20,140,685	0.000000	0.000000	2,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,801,104	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	129,869,545			12,911,766	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/31/2016 8:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03610	SLEEP LAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/31/2016 8:44 am

Title XVIII | Hospital | Cost

		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	0.133690	0	3,304,249	0	0	50.00
51.00	05100	RECOVERY ROOM	0.184932	0	682,766	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091644	0	9,276,868	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.117257	0	6,272,054	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.332780	0	245,508	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.267447	0	568,857	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.263497	0	136,325	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.314637	0	5,578	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113386	0	1,727,206	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.077518	0	556,238	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.204997	0	410,222	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130175	0	3,150,876	0	0	73.00
76.00	03610	SLEEP LAB	0.263791	0	287,666	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.808850	0	63,950	0	0	90.00
91.00	09100	EMERGENCY	0.316930	0	5,374,482	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.433297	0	755,398	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.118106		0			95.00
200.00		Subtotal (see instructions)		0	32,818,243	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	32,818,243	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/31/2016 8:44 am

Title XVIII | Hospital | Cost

		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	441,745	0	50.00
51.00	05100	RECOVERY ROOM	126,265	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	850,169	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	735,442	0	60.00
65.00	06500	RESPIRATORY THERAPY	81,700	0	65.00
66.00	06600	PHYSICAL THERAPY	152,139	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	35,921	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,755	0	68.00
69.00	06900	ELECTROCARDIOLOGY	195,841	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,118	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	84,094	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	410,165	0	73.00
76.00	03610	SLEEP LAB	75,884	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	51,726	0	90.00
91.00	09100	EMERGENCY	1,703,335	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	327,312	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	5,316,611	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	5,316,611	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151318 | Component CCN: 15Z318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/31/2016 8:44 am

Title XVIII | Swing Beds - SNF | Cost

		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	0.133690	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.184932	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091644	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.117257	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.332780	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.267447	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.263497	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.314637	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113386	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.077518	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.204997	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130175	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0.263791	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.808850	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.316930	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.433297	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.118106		0			95.00
200.00		Subtotal (see instructions)		0	0	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	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/31/2016 8:44 am

Component CCN: 15Z318 | Title XVIII | Swing Beds - SNF | Cost

		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
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03610	SLEEP LAB	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I Date/Time Prepared: 5/31/2016 8:44 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	900,971	0	900,971	3,706	243.11	30.00
31.00	INTENSIVE CARE UNIT	107,815		107,815	453	238.00	31.00
43.00	NURSERY	20,928		20,928	400	52.32	43.00
200.00	Total (lines 30-199)	1,029,714		1,029,714	4,559		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	109	26,499				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	109	26,499				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/31/2016 8:44 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	410,801	17,513,871	0.023456	126,194	2,960	50.00
51.00	05100	RECOVERY ROOM	35,309	3,058,450	0.011545	16,743	193	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	309,100	30,535,234	0.010123	75,040	760	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	162,962	20,776,974	0.007843	95,950	753	60.00
65.00	06500	RESPIRATORY THERAPY	52,489	1,897,283	0.027665	25,150	696	65.00
66.00	06600	PHYSICAL THERAPY	64,493	2,819,249	0.022876	10,873	249	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,157	1,002,790	0.021098	9,508	201	67.00
68.00	06800	SPEECH PATHOLOGY	928	64,557	0.014375	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	39,897	4,889,997	0.008159	14,815	121	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,357	4,885,926	0.003757	33,779	127	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,980	3,553,562	0.009562	85,291	816	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	81,214	15,508,092	0.005237	165,868	869	73.00
76.00	03610	SLEEP LAB	44,678	823,303	0.054267	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	33,626	598,468	0.056187	118	7	90.00
91.00	09100	EMERGENCY	273,480	20,140,685	0.013578	37,093	504	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	175,770	1,801,104	0.097590	3,237	316	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,758,241	129,869,545		699,659	8,572	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/31/2016 8:44 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
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,706	0.00	109	0		30.00
31.00	03100	INTENSIVE CARE UNIT	453	0.00	0	0		31.00
43.00	04300	NURSERY	400	0.00	0	0		43.00
200.00		Total (lines 30-199)	4,559		109	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/31/2016 8:44 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
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/31/2016 8:44 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	17,513,871	0.000000	0.000000	126,194	50.00
51.00	05100	RECOVERY ROOM	0	3,058,450	0.000000	0.000000	16,743	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,535,234	0.000000	0.000000	75,040	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	20,776,974	0.000000	0.000000	95,950	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,897,283	0.000000	0.000000	25,150	65.00
66.00	06600	PHYSICAL THERAPY	0	2,819,249	0.000000	0.000000	10,873	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,002,790	0.000000	0.000000	9,508	67.00
68.00	06800	SPEECH PATHOLOGY	0	64,557	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,889,997	0.000000	0.000000	14,815	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,885,926	0.000000	0.000000	33,779	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,553,562	0.000000	0.000000	85,291	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,508,092	0.000000	0.000000	165,868	73.00
76.00	03610	SLEEP LAB	0	823,303	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	598,468	0.000000	0.000000	118	90.00
91.00	09100	EMERGENCY	0	20,140,685	0.000000	0.000000	37,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,801,104	0.000000	0.000000	3,237	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	129,869,545			699,659	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/31/2016 8:44 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
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03610	SLEEP LAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/31/2016 8:44 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	0.133690	0	326,442	0	0	50.00
51.00	05100	RECOVERY ROOM	0.184932	0	68,074	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091644	0	764,046	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.117257	0	608,693	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.332780	0	15,793	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.267447	0	38,653	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.263497	0	3,867	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.314637	0	5,369	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113386	0	97,043	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.077518	0	116,778	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.204997	0	18,709	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130175	0	176,179	0	0	73.00
76.00	03610	SLEEP LAB	0.263791	0	34,377	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.808850	0	8,673	0	0	90.00
91.00	09100	EMERGENCY	0.316930	0	796,868	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.433297	0	62,379	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.118106	0	189,073			95.00
200.00		Subtotal (see instructions)		0	3,331,016	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	3,331,016	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/31/2016 8:44 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	43,642	0		50.00
51.00	05100	RECOVERY ROOM	12,589	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	70,020	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	71,374	0		60.00
65.00	06500	RESPIRATORY THERAPY	5,256	0		65.00
66.00	06600	PHYSICAL THERAPY	10,338	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,019	0		67.00
68.00	06800	SPEECH PATHOLOGY	1,689	0		68.00
69.00	06900	ELECTROCARDIOLOGY	11,003	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,052	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,835	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,934	0		73.00
76.00	03610	SLEEP LAB	9,068	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	7,015	0		90.00
91.00	09100	EMERGENCY	252,551	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	27,029	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	22,331			95.00
200.00		Subtotal (see instructions)	580,745	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	580,745	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151318	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/31/2016 8:44 am
	Title XVIII	Hospital	Cost

	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)	3,871	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,706	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.	453	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,530	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	165	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)	1,560	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)	148	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,178,404	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)	178,103	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,000,301	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	6,215,386	28.00
29.00	Private room charges (excluding swing-bed charges)	945,524	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	5,269,862	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.643613	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	2,087.25	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	2,082.95	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	4.30	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	2.77	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	1,255	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,999,046	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,079.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,683,349	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)	1,683,349	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/31/2016 8:44 am

Title XVIII | Hospital | Cost

	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	736,355	453	1,625.51	298	484,402	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)	1,883,623	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,051,374	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	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)	159,702	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)	159,702	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)	723	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,079.41	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	780,413	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/31/2016 8:44 am

Title XVIII | Hospital | Cost

	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	900,971	4,000,301	0.225226	780,413	175,769	90.00
91.00	Nursing School cost	0	4,000,301	0.000000	780,413	0	91.00
92.00	Allied health cost	0	4,000,301	0.000000	780,413	0	92.00
93.00	All other Medical Education	0	4,000,301	0.000000	780,413	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151318	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/31/2016 8:44 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)	3,871	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,706	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)	2,983	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)	109	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)	400	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,178,404	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,178,404	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)	4,178,404	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,127.47	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	122,894	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)	122,894	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/31/2016 8:44 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)	232,860	400	582.15	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	736,355	453	1,625.51	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)	108,505	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	231,399	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)	26,499	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	8,572	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	35,071	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	196,328	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)	723	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,127.47	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	815,161	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/31/2016 8:44 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	900,971	4,178,404	0.215626	815,161	175,770	90.00
91.00	Nursing School cost	0	4,178,404	0.000000	815,161	0	91.00
92.00	Allied health cost	0	4,178,404	0.000000	815,161	0	92.00
93.00	All other Medical Education	0	4,178,404	0.000000	815,161	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/31/2016 8:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,568,750		30.00
31.00	03100	INTENSIVE CARE UNIT		728,491		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.133690	1,367,757	182,855	50.00
51.00	05100	RECOVERY ROOM	0.184932	188,028	34,772	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091644	1,576,820	144,506	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.117257	1,748,590	205,034	60.00
65.00	06500	RESPIRATORY THERAPY	0.332780	824,437	274,356	65.00
66.00	06600	PHYSICAL THERAPY	0.267447	248,023	66,333	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.263497	246,570	64,970	67.00
68.00	06800	SPEECH PATHOLOGY	0.314637	14,453	4,547	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113386	666,670	75,591	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.077518	936,742	72,614	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.204997	1,244,618	255,143	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130175	3,836,059	499,359	73.00
76.00	03610	SLEEP LAB	0.263791	10,863	2,866	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.808850	0	0	90.00
91.00	09100	EMERGENCY	0.316930	2,136	677	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.433297	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		12,911,766	1,883,623	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)		12,911,766		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151318 | Component CCN: 15Z318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/31/2016 8:44 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		107,770		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.133690	0	0	50.00
51.00	05100	RECOVERY ROOM	0.184932	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091644	6,348	582	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.117257	21,931	2,572	60.00
65.00	06500	RESPIRATORY THERAPY	0.332780	26,010	8,656	65.00
66.00	06600	PHYSICAL THERAPY	0.267447	99,868	26,709	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.263497	101,228	26,673	67.00
68.00	06800	SPEECH PATHOLOGY	0.314637	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113386	615	70	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.077518	23,374	1,812	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.204997	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130175	86,374	11,244	73.00
76.00	03610	SLEEP LAB	0.263791	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.808850	0	0	90.00
91.00	09100	EMERGENCY	0.316930	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.433297	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		365,748	78,318	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)		365,748		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/31/2016 8:44 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		114,915		30.00
31.00	03100	INTENSIVE CARE UNIT		24,300		31.00
43.00	04300	NURSERY		37,842		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.133690	126,194	16,871	50.00
51.00	05100	RECOVERY ROOM	0.184932	16,743	3,096	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091644	75,040	6,877	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.117257	95,950	11,251	60.00
65.00	06500	RESPIRATORY THERAPY	0.332780	25,150	8,369	65.00
66.00	06600	PHYSICAL THERAPY	0.267447	10,873	2,908	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.263497	9,508	2,505	67.00
68.00	06800	SPEECH PATHOLOGY	0.314637	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113386	14,815	1,680	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.077518	33,779	2,618	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.204997	85,291	17,484	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130175	165,868	21,592	73.00
76.00	03610	SLEEP LAB	0.263791	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.808850	118	95	90.00
91.00	09100	EMERGENCY	0.316930	37,093	11,756	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.433297	3,237	1,403	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		699,659	108,505	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)		699,659		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151318	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/31/2016 8:44 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,316,611	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	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)	5,316,611	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,369,777	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	5,707	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	5,365,359	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	-1,289	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	-1,289	30.00
31.00	Primary payer payments	1,185	31.00
32.00	Subtotal (line 30 minus line 31)	-2,474	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)	1,277,632	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	830,461	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	907,383	36.00
37.00	Subtotal (see instructions)	827,987	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)	827,987	40.00
40.01	Sequestration adjustment (see instructions)	16,560	40.01
41.00	Interim payments	1,963,967	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-1,152,540	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: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I Date/Time Prepared: 5/31/2016 8:44 am

Title XVIII | Hospital | Cost

		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		3,686,519		1,963,967	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	08/07/2015	317,200		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)		317,200		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,003,719		1,963,967	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		458,093		1,152,540	6.02
7.00	Total Medicare program liability (see instructions)		3,545,626		811,427	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: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2016 8:44 am

Component CCN: 15Z318 | Title XVIII | Swing Beds - SNF | Cost

		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		250,758		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/07/2015	25,900		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)		25,900		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)		276,658		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		41,066		0	6.02
7.00	Total Medicare program liability (see instructions)		235,592		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151318	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/31/2016 8:44 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,127	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,858	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	297	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	3,436	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	142,606,323	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	30,521	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 - SWING BEDS	Provider CCN: 151318 Component CCN: 15Z318	Period: From 01/01/2015 To 12/31/2015	Worksheet E-2 Date/Time Prepared: 5/31/2016 8:44 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	161,299	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	79,101	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	148	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	240,400	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	240,400	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	240,400	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	240,400	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	240,400	0	19.00
19.01	Sequestration adjustment (see instructions)	4,808	0	19.01
20.00	Interim payments	276,658	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-41,066	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151318	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part V Date/Time Prepared: 5/31/2016 8:44 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,051,374	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	4,051,374	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,091,888	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	4,091,888	19.00
20.00	Deductibles (exclude professional component)	513,948	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,577,940	22.00
23.00	Coinsurance	3,780	23.00
24.00	Subtotal (line 22 minus line 23)	3,574,160	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	71,900	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	46,735	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	21,585	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,620,895	28.00
29.00	MSP	-2,909	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	3,617,986	30.00
30.01	Sequestration adjustment (see instructions)	72,360	30.01
31.00	Interim payments	4,003,719	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	-458,093	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	528,559	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/31/2016 8:44 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	-60,630	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	13,385,403	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,472,065	0	0	0	6.00
7.00	Inventory	957,640	0	0	0	7.00
8.00	Prepaid expenses	141,161	0	0	0	8.00
9.00	Other current assets	223,767	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,175,276	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	500,000	0	0	0	12.00
13.00	Land improvements	218,645	0	0	0	13.00
14.00	Accumulated depreciation	-81,779	0	0	0	14.00
15.00	Buildings	10,464,466	0	0	0	15.00
16.00	Accumulated depreciation	-2,514,011	0	0	0	16.00
17.00	Leasehold improvements	5,801,929	0	0	0	17.00
18.00	Accumulated depreciation	-1,599,518	0	0	0	18.00
19.00	Fixed equipment	1,656,618	0	0	0	19.00
20.00	Accumulated depreciation	-580,963	0	0	0	20.00
21.00	Automobiles and trucks	540,643	0	0	0	21.00
22.00	Accumulated depreciation	-370,198	0	0	0	22.00
23.00	Major movable equipment	6,010,358	0	0	0	23.00
24.00	Accumulated depreciation	-4,333,011	0	0	0	24.00
25.00	Minor equipment depreciable	2,813,741	0	0	0	25.00
26.00	Accumulated depreciation	-1,978,400	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)	16,548,520	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	296,844	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	296,844	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	29,020,640	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,129,140	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,063,941	0	0	0	38.00
39.00	Payroll taxes payable	83,031	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	-13,651,099	0	0	0	43.00
44.00	Other current liabilities	482,767	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-10,892,220	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	-10,892,220	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	39,912,860				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)	39,912,860	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	29,020,640	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/31/2016 8:44 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		30,190,810		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,722,050				2.00
3.00	Total (sum of line 1 and line 2)		39,912,860		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)		39,912,860		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)		39,912,860		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: 151318 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/31/2016 8:44 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,273,859		5,273,859	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	5,273,859		5,273,859	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	945,524		945,524	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)	945,524		945,524	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,219,383		6,219,383	17.00
18.00	Ancillary services	32,972,981	0	32,972,981	18.00
19.00	Outpatient services	0	103,413,959	103,413,959	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	39,192,364	103,413,959	142,606,323	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		29,076,603		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)		29,076,603		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151318	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prepared: 5/31/2016 8:44 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	142,606,323	1.00
2.00	Less contractual allowances and discounts on patients' accounts	103,932,412	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,673,911	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,076,603	4.00
5.00	Net income from service to patients (line 3 minus line 4)	9,597,308	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	124,742	24.00
25.00	Total other income (sum of lines 6-24)	124,742	25.00
26.00	Total (line 5 plus line 25)	9,722,050	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,722,050	29.00