

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: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet S Parts I-III Date/Time Prepared: 7/29/2016 9:00 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 7/29/2016 Time: 9:00 am
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 KOSCIUSKO COMMUNITY HOSPITAL (150133) for the cost reporting period beginning 03/01/2015 and ending 02/29/2016 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 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	65,513	77,337	16,083	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	65,513	77,337	16,083	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: 150133		Period: From 03/01/2015 To 02/29/2016		Worksheet S-2 Part I Date/Time Prepared: 7/27/2016 2:06 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 2101 EAST DUBOIS DRIVE		PO Box:						1.00		
2.00	City: WARSAW		State: IN		Zip Code: 46580-		County: KOSCIUSKO		2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		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		KOSCIUSKO COMMUNITY HOSPITAL	150133	99915	1	07/01/1966	0	P	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										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:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					03/01/2015	02/29/2016		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 §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	Y		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N	23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	292	368	0	5	1,492	64		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: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet S-2 Part I Date/Time Prepared: 7/27/2016 2:06 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N				37.01	
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	XVII	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		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		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		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	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

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	0.00	0.00				61.06
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.20	
					1.00		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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				
64.00	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. 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	

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		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
				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	2.00	3.00
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.			N		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	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 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	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	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	97.00	
Rural Providers						
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.				N	110.00
					1.00	
					2.00	
					3.00	
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	30,816	233,263		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
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150133		Period: From 03/01/2015 To 02/29/2016		Worksheet S-2 Part I Date/Time Prepared: 7/27/2016 2:06 pm		
		1.00	2.00					
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	
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		
141.00	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.							
	Name: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS		Contractor's Number: 52280			141.00	
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		Zip Code: 37067			142.00	
143.00	City: FRANKLIN	State: TN					143.00	
						1.00		
144.00	Are provider based physicians' costs included in Worksheet A?		Y				144.00	
		1.00	2.00					
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00	
						1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N				149.00	
				Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00			
155.00	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)	N	N	N	N		155.00	
156.00	Hospital	N	N	N	N		156.00	
157.00	Subprovider - IPF	N	N	N	N		157.00	
158.00	Subprovider - IRF	N	N	N	N		158.00	
159.00	SUBPROVIDER						159.00	
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	N		161.00	
						1.00		
165.00	Multi campus Is this hospital part of a Multi campus 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	
							1.00	
167.00	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 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)						168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.25	169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet S-2 Part I Date/Time Prepared: 7/27/2016 2:06 pm	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10/01/2014	12/29/2014	170.00
			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: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet S-2 Part II Date/Time Prepared: 7/27/2016 2:06 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	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)	Y	06/27/2016	Y	06/27/2016
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet S-2 Part II Date/Time Prepared: 7/27/2016 2:06 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
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
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2015	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.	MI CHAEL		TEA	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 628-6555		MI CHAEL_TEA@CHS.NET	43.00

		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.	DIRECTOR, REVENUE MANAGEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet S-3
Part I
Date/Time Prepared:
7/27/2016 2:06 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	58	21,228	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		58	21,228	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	14	5,124	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		72	26,352	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						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)		72				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: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet S-3
Part I
Date/Time Prepared:
7/27/2016 2:06 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	3,726	1,290	9,867			1.00
2.00 HMO and other (see instructions)	2,530	201				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,726	1,290	9,867			7.00
8.00 INTENSIVE CARE UNIT	681	247	1,558			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		483	1,011			13.00
14.00 Total (see instructions)	4,407	2,020	12,436	0.00	458.97	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	458.97	27.00
28.00 Observation Bed Days		0	2,611			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: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet S-3
Part I
Date/Time Prepared:
7/27/2016 2:06 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,223	527	3,703	1.00
2.00 HMO and other (see instructions)			715	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	1,223	527	3,703	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: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet S-3
Part II
Date/Time Prepared:
7/27/2016 2:06 pm

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	22,916,090	0	22,916,090	954,660.00	24.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		29,735	141,557	171,292	7,619.00	22.48
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,348,775	0	1,348,775	35,949.75	37.52
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		339,616	0	339,616	2,502.45	135.71
14.00	Home office salaries & wage-related costs		1,519,274	0	1,519,274	28,151.00	53.97
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,757,149	0	4,757,149		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		38,361	0	38,361		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	161,757	0	161,757	6,265.00	25.82
27.00	Administrative & General	5.00	3,423,771	-308,236	3,115,535	143,913.00	21.65
28.00	Administrative & General under contract (see inst.)		11,387	0	11,387	102.48	111.11
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	507,101	0	507,101	25,188.00	20.13
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	581,621	0	581,621	44,462.00	13.08
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	574,074	-412,020	162,054	11,646.67	13.91
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	412,020	412,020	29,611.33	13.91
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,042,018	166,679	1,208,697	37,413.00	32.31
39.00	Central Services and Supply	14.00	241,523	0	241,523	15,436.00	15.65
40.00	Pharmacy	15.00	827,292	0	827,292	20,632.00	40.10

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet S-3
Part II
Date/Time Prepared:
7/27/2016 2:06 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es 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	16.00 535,756	0	535,756	28,651.00	18.70	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: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet S-3
Part III
Date/Time Prepared:
7/27/2016 2:06 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries 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)	22,927,477	0	22,927,477	954,762.48	24.01	1.00
2.00	Excluded area salaries (see instructions)	29,735	141,557	171,292	7,619.00	22.48	2.00
3.00	Subtotal salaries (line 1 minus line 2)	22,897,742	-141,557	22,756,185	947,143.48	24.03	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,207,665	0	3,207,665	66,603.20	48.16	4.00
5.00	Subtotal wage-related costs (see inst.)	4,757,149	0	4,757,149	0.00	20.90	5.00
6.00	Total (sum of lines 3 thru 5)	30,862,556	-141,557	30,720,999	1,013,746.68	30.30	6.00
7.00	Total overhead cost (see instructions)	7,906,300	-141,557	7,764,743	363,320.48	21.37	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet S-3 Part IV Date/Time Prepared: 7/27/2016 2:06 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		390,442	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)		2,335,547	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		36,739	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		29,801	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		1,885	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		18,319	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		168,097	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		1,294,962	17.00
18.00	Medicare Taxes - Employers Portion Only		302,854	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		86,898	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)		4,665,544	24.00
Part B - Other than Core Related Cost				
25.00	OTHER BENEFITS		129,965	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet S-3 Part V Date/Time Prepared: 7/27/2016 2:06 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet S-10

Date/Time Prepared:
7/27/2016 2:06 pm

				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.112875	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			7,576,398	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			79,770,915	6.00
7.00	Medicaid cost (line 1 times line 6)			9,004,142	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)			1,427,744	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)			26,070	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			431,676	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			48,725	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)			22,655	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)			1,450,399	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	878,256	289,066	1,167,322	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	99,133	32,628	131,761	21.00
22.00	Partial payment by patients approved for charity care	1,625	0	1,625	22.00
23.00	Cost of charity care (line 21 minus line 22)	97,508	32,628	130,136	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)			22,494,791	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			229,517	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			22,265,274	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			2,513,193	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,643,329	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,093,728	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet A Date/Time Prepared: 7/27/2016 2:06 pm		
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT		1,757,132	1,757,132	909,590	2,666,722	1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		3,365,520	3,365,520	878,887	4,244,407	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	161,757	116,689	278,446	3,092,923	3,371,369	4.00
5.01 00540	OTHER ADMINISTRATIVE AND GENERAL	3,423,771	14,903,617	18,327,388	-9,012,856	9,314,532	5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	4,535,878	4,535,878	5.02
7.00 00700	OPERATION OF PLANT	507,101	1,619,135	2,126,236	51,189	2,177,425	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	319,417	319,417	0	319,417	8.00
9.00 00900	HOUSEKEEPING	581,621	228,725	810,346	0	810,346	9.00
10.00 01000	DIETARY	574,074	630,687	1,204,761	-864,817	339,944	10.00
11.00 01100	CAFETERIA	0	0	0	864,298	864,298	11.00
13.00 01300	NURSING ADMINISTRATION	1,042,018	137,877	1,179,895	164,307	1,344,202	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	241,523	3,011,098	3,252,621	-2,743,989	508,632	14.00
15.00 01500	PHARMACY	827,292	5,584,109	6,411,401	-5,138,467	1,272,934	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	535,756	283,130	818,886	-1,214	817,672	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	4,157,161	1,978,799	6,135,960	-696,857	5,439,103	30.00
31.00 03100	INTENSIVE CARE UNIT	1,151,963	194,099	1,346,062	-3,890	1,342,172	31.00
43.00 04300	NURSERY	0	0	0	204,215	204,215	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	1,257,561	1,337,878	2,595,439	-12,826	2,582,613	50.00
51.00 05100	RECOVERY ROOM	655,755	130,866	786,621	-1,105	785,516	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	12	12	486,705	486,717	52.00
53.00 05300	ANESTHESIOLOGY	0	787,132	787,132	-15,777	771,355	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,106,890	2,130,206	4,237,096	-1,794,724	2,442,372	54.00
54.01 05401	ULTRASOUND	461,134	72,979	534,113	-534,113	0	54.01
54.02 05402	ONCOLOGY	0	0	0	1,786,507	1,786,507	54.02
56.00 05600	RADIOISOTOPE	148,520	214,538	363,058	0	363,058	56.00
57.00 05700	CT SCAN	265,802	312,038	577,840	-37,087	540,753	57.00
58.00 05800	MRI	207,467	134,213	341,680	0	341,680	58.00
60.00 06000	LABORATORY	1,345,564	2,010,942	3,356,506	-192,667	3,163,839	60.00
65.00 06500	RESPIRATORY THERAPY	391,836	69,696	461,532	116,982	578,514	65.00
66.00 06600	PHYSICAL THERAPY	595,980	1,180,651	1,776,631	-2,392	1,774,239	66.00
67.00 06700	OCCUPATIONAL THERAPY	22,407	192,415	214,822	-799	214,023	67.00
68.00 06800	SPEECH PATHOLOGY	0	30,975	30,975	0	30,975	68.00
69.00 06900	ELECTROCARDIOLOGY	74,701	10,333	85,034	0	85,034	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	456,209	456,209	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,260,272	2,260,272	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,013,304	5,013,304	73.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01 03610	SLEEP LAB	74,559	42,909	117,468	-117,468	0	76.01
76.03 03951	OTHER ANCILLARY SERVICE COST CENTER	65,777	31,965	97,742	-97,742	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	467,376	41,341	508,717	94,718	603,435	90.00
91.00 09100	EMERGENCY	1,540,989	527,217	2,068,206	-52,071	2,016,135	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,886,355	43,388,340	66,274,695	-404,877	65,869,818	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	29,735	25,334	55,069	-913	54,156	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	60,173	60,173	-119,810	-59,637	192.00
192.01 19201	WELLNESS CENTER	0	0	0	0	0	192.01
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07951	MARKETING	0	0	0	522,136	522,136	194.01
194.02 07952	SENIOR CIRCLE	0	-3,464	-3,464	3,464	0	194.02
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.05 07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.05
200.00	TOTAL (SUM OF LINES 118-199)	22,916,090	43,470,383	66,386,473	0	66,386,473	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet A
Date/Time Prepared:
7/27/2016 2:06 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,987,438	5,654,160	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-534,422	3,709,985	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,582	3,369,787	4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	-498,931	8,815,601	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-1,382,289	3,153,589	5.02
7.00	00700	OPERATION OF PLANT	0	2,177,425	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-10,735	308,682	8.00
9.00	00900	HOUSEKEEPING	0	810,346	9.00
10.00	01000	DIETARY	0	339,944	10.00
11.00	01100	CAFETERIA	-347,125	517,173	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,344,202	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	508,632	14.00
15.00	01500	PHARMACY	0	1,272,934	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13,193	804,479	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,292,706	4,146,397	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,342,172	31.00
43.00	04300	NURSERY	0	204,215	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-108,650	2,473,963	50.00
51.00	05100	RECOVERY ROOM	0	785,516	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	486,717	52.00
53.00	05300	ANESTHESIOLOGY	-771,355	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,745	2,440,627	54.00
54.01	05401	ULTRASOUND	0	0	54.01
54.02	05402	ONCOLOGY	-257,637	1,528,870	54.02
56.00	05600	RADIOISOTOPE	-315	362,743	56.00
57.00	05700	CT SCAN	-8,381	532,372	57.00
58.00	05800	MRI	-19,695	321,985	58.00
60.00	06000	LABORATORY	0	3,163,839	60.00
65.00	06500	RESPIRATORY THERAPY	0	578,514	65.00
66.00	06600	PHYSICAL THERAPY	0	1,774,239	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	214,023	67.00
68.00	06800	SPEECH PATHOLOGY	0	30,975	68.00
69.00	06900	ELECTROCARDIOLOGY	0	85,034	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	456,209	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,260,272	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,013,304	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.03	03951	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	603,435	90.00
91.00	09100	EMERGENCY	0	2,016,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,261,323	63,608,495	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54,156	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	198,223	138,586	192.00
192.01	19201	WELLNESS CENTER	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	MARKETING	0	522,136	194.01
194.02	07952	SENIOR CIRCLE	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.03
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.05
200.00		TOTAL (SUM OF LINES 118-199)	-2,063,100	64,323,373	200.00

RECLASSIFICATIONS

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet A-6
Date/Time Prepared:
7/27/2016 2:06 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,095,694	1.00
	TOTALS		0	3,095,694	
B - OXYGEN					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	24,253	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	24,253	
C - LEASE AND RENTAL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	214,681	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	863,350	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
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	1,078,031	
D - OTHER CAPITAL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	119,422	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	575,487	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,537	3.00
	TOTALS		0	710,446	
E - MARKETING					
1.00	MARKETING	194.01	141,557	384,043	1.00
	TOTALS		141,557	384,043	
F - CNO COST					
1.00	NURSING ADMINISTRATION	13.00	166,679	0	1.00
	TOTALS		166,679	0	
G - CHARGABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	431,956	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,260,272	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	2,692,228	
H - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,013,304	1.00
	TOTALS		0	5,013,304	
I - LABOR AND DELIVERY					
1.00	NURSERY	43.00	173,247	30,968	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	412,908	73,797	2.00
	TOTALS		586,155	104,765	
J - MISC DEPARTMENTS					
1.00	CLINIC	90.00	65,777	31,965	1.00
2.00	RESPIRATORY THERAPY	65.00	74,559	42,423	2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	1,432,251	3,103,627	3.00
4.00	SENIOR CIRCLE	194.02	0	3,464	4.00
	TOTALS		1,572,587	3,181,479	
K - RADIOLOGY					
1.00	ONCOLOGY	54.02	736,081	1,050,426	1.00
2.00		0.00	0	0	2.00
	TOTALS		736,081	1,050,426	
L - DIETARY					
1.00	CAFETERIA	11.00	412,020	452,278	1.00
	TOTALS		412,020	452,278	
M - MOB UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	52,005	1.00
	TOTALS		0	52,005	
500.00	Grand Total: Increases		3,615,079	17,838,952	500.00

RECLASSIFICATIONS

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet A-6
Date/Time Prepared:
7/27/2016 2:06 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	3,095,694	0	1.00
	TOTALS		0	3,095,694		
B - OXYGEN						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	8,476	0	1.00
2.00	ANESTHESIOLOGY	53.00	0	15,777	0	2.00
	TOTALS		0	24,253		
C - LEASE AND RENTAL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,771	10	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	46,364	10	2.00
3.00	OPERATION OF PLANT	7.00	0	816	0	3.00
4.00	DIETARY	10.00	0	519	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	2,372	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	45,959	0	6.00
7.00	PHARMACY	15.00	0	125,163	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,214	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	5,937	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	3,890	0	10.00
11.00	OPERATING ROOM	50.00	0	10,292	0	11.00
12.00	RECOVERY ROOM	51.00	0	1,105	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	542,330	0	13.00
14.00	CT SCAN	57.00	0	37,087	0	14.00
16.00	LABORATORY	60.00	0	192,667	0	16.00
17.00	PHYSICAL THERAPY	66.00	0	2,392	0	17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	799	0	18.00
19.00	SLEEP LAB	76.01	0	486	0	19.00
20.00	CLINIC	90.00	0	2,884	0	20.00
21.00	EMERGENCY	91.00	0	52,071	0	21.00
22.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	913	0	22.00
	TOTALS		0	1,078,031		
D - OTHER CAPITAL						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	642,641	12	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	67,805	13	2.00
3.00		0.00	0	0	12	3.00
	TOTALS		0	710,446		
E - MARKETING						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	141,557	384,043	0	1.00
	TOTALS		141,557	384,043		
F - CNO COST						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	166,679	0	0	1.00
	TOTALS		166,679	0		
G - CHARGABLE SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,689,554	0	1.00
2.00	OPERATING ROOM	50.00	0	2,534	0	2.00
3.00	CLINIC	90.00	0	140	0	3.00
	TOTALS		0	2,692,228		
H - DRUGS						
1.00	PHARMACY	15.00	0	5,013,304	0	1.00
	TOTALS		0	5,013,304		
I - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	586,155	104,765	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		586,155	104,765		
J - MISC DEPARTMENTS						
1.00	OTHER ANCILLARY SERVICE COST CENTER	76.03	65,777	31,965	0	1.00
2.00	SLEEP LAB	76.01	74,559	42,423	0	2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	1,432,251	3,103,627	0	3.00
4.00	MARKETING	194.01	0	3,464	0	4.00
	TOTALS		1,572,587	3,181,479		
K - RADIOLOGY						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	274,947	977,447	0	1.00
2.00	ULTRASOUND	54.01	461,134	72,979	0	2.00
	TOTALS		736,081	1,050,426		

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet A-6
Date/Time Prepared:
7/27/2016 2:06 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
L - DIETARY						
1.00	DIETARY	10.00	412,020	452,278	0	1.00
	TOTALS		412,020	452,278		
M - MOB UTILITIES						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	52,005	0	1.00
	TOTALS		0	52,005		
500.00	Grand Total: Decreases		3,615,079	17,838,952		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet A-7
Part I
Date/Time Prepared:
7/27/2016 2:06 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	158,709	0	0	0	1.00
2.00	Land Improvements	1,501,575	38,362	0	38,362	2.00
3.00	Buildings and Fixtures	54,569,700	507,058	0	507,058	3.00
4.00	Building Improvements	134,232	27,700	0	27,700	4.00
5.00	Fixed Equipment	4,033,687	114,111	0	114,111	5.00
6.00	Movable Equipment	35,104,905	1,102,252	0	1,102,252	6.00
7.00	HIT designated Assets	2,375,096	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	97,877,904	1,789,483	0	1,789,483	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	97,877,904	1,789,483	0	1,789,483	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	158,709	0			1.00
2.00	Land Improvements	1,539,273	0			2.00
3.00	Buildings and Fixtures	55,076,758	0			3.00
4.00	Building Improvements	161,932	0			4.00
5.00	Fixed Equipment	4,147,798	0			5.00
6.00	Movable Equipment	36,017,048	0			6.00
7.00	HIT designated Assets	2,274,321	0			7.00
8.00	Subtotal (sum of lines 1-7)	99,375,839	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	99,375,839	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet A-7
Part II
Date/Time Prepared:
7/27/2016 2:06 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,757,132	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,365,520	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,122,652	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,757,132				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,365,520				2.00
3.00	Total (sum of lines 1-2)	0	5,122,652				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet A-7
Part III
Date/Time Prepared:
7/27/2016 2:06 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	56,936,673	0	56,936,673	0.572943	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	42,439,167	0	42,439,167	0.427057	0	2.00
3.00	Total (sum of lines 1-2)	99,375,840	0	99,375,840	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,487,707	128,242	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,712,406	863,350	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,200,113	991,592	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	2,298,916	119,422	575,487	44,386	5,654,160	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	15,537	0	118,692	3,709,985	2.00
3.00	Total (sum of lines 1-2)	2,298,916	134,959	575,487	163,078	9,364,145	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet A-8

Date/Time Prepared:
7/27/2016 2:06 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst.	A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	B	-816	0	OTHER ADMINISTRATIVE AND GENERAL	5.01		0	7.00
8.00 Television and radio service (chapter 21)	A	-27,925	0	CAP REL COSTS-MVBLE EQUIP	2.00		9	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,470,533	0				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-76	0	RADIOLOGY-DIAGNOSTIC	54.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,619,543	0				0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-347,125	0	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	-13,193	0	MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines			0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	730,575	0	CAP REL COSTS-BLDG & FIXT	1.00		9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-651,402	0	CAP REL COSTS-MVBLE EQUIP	2.00		9	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00			0		0.00		0	33.00
34.00 RENTAL INCOME	B	-86,439	0	CAP REL COSTS-BLDG & FIXT	1.00		10	34.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
35.00 MISC INCOME	B	-103,974	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 35.00
36.00		0		0.00	0 36.00
37.00 PATIENT PHONE WAGE COST	A	-7,559	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 37.00
38.00 PATIENT PHONE BENEFIT COSTS	A	-1,582	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 38.00
39.00 PATIENT PHONE EXPENSE	A	-9,730	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 39.00
40.00 PATIENT PHONE DEPRECIATION	A	-948	CAP REL COSTS-MVBLE EQUIP	2.00	9 40.00
41.00 PATIENT TV - DEPRECIATION	A	-9,506	CAP REL COSTS-MVBLE EQUIP	2.00	9 41.00
42.00 MARKETING	A	-422,083	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 42.00
43.00 PHYSICIAN RECRUITING	A	-3,048	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 43.00
44.00 CHARITABLE CONTRIBUTIONS	A	-30,011	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 44.00
45.00 UNCOLLECTED PHYSICIAN RENT	A	11,074	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 45.00
45.01 MINORITY INTEREST	A	-391,547	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 45.01
45.02 LOBBYING EXPENSE IN ASSOCIATION DUES	A	-6,366	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 45.02
45.03 TRANSPORTATION COSTS	A	-1,708	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 45.03
45.04 LEGAL FEES	A	-20,975	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 45.04
45.05 POB DEPRECIATION	A	-197,449	PHYSICIANS' PRIVATE OFFICES	192.00	0 45.05
45.06 POB RENT	A	395,672	PHYSICIANS' PRIVATE OFFICES	192.00	0 45.06
45.07		0		0.00	0 45.07
45.08		0		0.00	0 45.08
45.09 MEALS AND ENTERTAINMENT	A	-15,969	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 45.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,063,100			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: 150133

Period: From 03/01/2015 To 02/29/2016

Worksheet A-8-1

Date/Time Prepared: 7/27/2016 2:06 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION - CAPITAL-	2,298,916	0
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	26,712	0
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	3,902	0
4.00	5.01	OTHER ADMINISTRATIVE AND GEN	PASI OPERATING COSTS	418,065	0
4.01	1.00	CAP REL COSTS-BLDG & FIXT	PRE-ACQ LEGACY CAPITAL COSTS	3,464	0
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	PRE-ACQ LEGACY CAPITAL COSTS	20,452	0
4.03	5.01	OTHER ADMINISTRATIVE AND GEN	PRE- ACQ PERIOD NON-CAPITAL	212,499	0
4.04	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	14,210	0
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	94,338	0
4.06	5.01	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL HOME OFFICE COST	1,361,023	0
4.07	5.01	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE COSTS (SEE EXHIB	233,263	0
4.08	5.02	OTHER ADMINISTRATIVE AND GEN	CIG LEASED EQUIPMENT (SEE EX	145,827	0
4.09	5.02	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEES	0	798,387
4.10	5.01	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	5,271
4.11	5.01	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	63,468
4.12	5.01	OTHER ADMINISTRATIVE AND GEN	CORPORATE OVERHEAD ALLOCATIO	0	1,449,372
4.13	0.00			0	0
4.14	0.00			0	0
4.15	0.00			0	0
4.16	0.00			0	0
4.17	0.00			0	0
4.18	5.01	OTHER ADMINISTRATIVE AND GEN	PPSI FEES	0	25,550
4.19	0.00			0	0
4.20	0.00			0	0
4.21	5.02	OTHER ADMINISTRATIVE AND GEN	PASI COLLECTION FEES	0	371,646
4.22	5.02	OTHER ADMINISTRATIVE AND GEN	EBOS FEES	0	11,685
4.23	5.02	OTHER ADMINISTRATIVE AND GEN	PASI LIEN UNIT COLLECTION FE	0	70,874
4.24	5.01	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE ALLOCATIONS (PER	0	184,572
4.25	5.02	OTHER ADMINISTRATIVE AND GEN	CIG LEASED EQUIPMENT (PER EX	0	258,235
4.26	2.00	CAP REL COSTS-MVBLE EQUIP	LAUNDRY CAPITAL	36,667	0
4.27	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY OPERATING	308,586	319,321
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,177,924	3,558,381

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	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 SYSTEMS	100.00	6.00
7.00	C	0.00	HOSPITAL LAUNDR	20.00	7.00
8.00	C	0.00	PASI	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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet A-8-1

Date/Time Prepared:
7/27/2016 2:06 pm

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00

(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: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet A-8-1

Date/Time Prepared:
7/27/2016 2:06 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	2,298,916	11		1.00
2.00	26,712	14		2.00
3.00	3,902	14		3.00
4.00	418,065	0		4.00
4.01	3,464	14		4.01
4.02	20,452	14		4.02
4.03	212,499	0		4.03
4.04	14,210	14		4.04
4.05	94,338	14		4.05
4.06	1,361,023	0		4.06
4.07	233,263	0		4.07
4.08	145,827	0		4.08
4.09	-798,387	0		4.09
4.10	-5,271	0		4.10
4.11	-63,468	0		4.11
4.12	-1,449,372	0		4.12
4.13	0	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	-25,550	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	-371,646	0		4.21
4.22	-11,685	0		4.22
4.23	-70,874	0		4.23
4.24	-184,572	0		4.24
4.25	-258,235	0		4.25
4.26	36,667	9		4.26
4.27	-10,735	0		4.27
5.00	1,619,543			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	LAUNDRY SERVICES		7.00
8.00	DEBT COLLECTION		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: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet A-8-2

Date/Time Prepared:
7/27/2016 2:06 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	10,125	10,125	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,292,706	1,292,706	0	0	0	2.00
3.00	50.00	OPERATING ROOM	108,650	108,650	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	771,355	771,355	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	1,669	1,669	0	0	0	5.00
6.00	54.02	ONCOLOGY	257,637	257,637	0	0	0	6.00
7.00	56.00	RADIOISOTOPE	315	315	0	0	0	7.00
8.00	57.00	CT SCAN	8,381	8,381	0	0	0	8.00
9.00	58.00	MRI	19,695	19,695	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,470,533	2,470,533	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.01	OTHER 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	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	54.02	ONCOLOGY	0	0	0	0	0	6.00
7.00	56.00	RADIOISOTOPE	0	0	0	0	0	7.00
8.00	57.00	CT SCAN	0	0	0	0	0	8.00
9.00	58.00	MRI	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	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	10,125		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,292,706		2.00
3.00	50.00	OPERATING ROOM	0	0	0	108,650		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	771,355		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,669		5.00
6.00	54.02	ONCOLOGY	0	0	0	257,637		6.00
7.00	56.00	RADIOISOTOPE	0	0	0	315		7.00
8.00	57.00	CT SCAN	0	0	0	8,381		8.00
9.00	58.00	MRI	0	0	0	19,695		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,470,533		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150133

Period: From 03/01/2015 To 02/29/2016

Worksheet B Part I Date/Time Prepared: 7/27/2016 2:06 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	5,654,160	5,654,160			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	3,709,985		3,709,985		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,369,787	14,212	9,325	3,393,324	4.00
5.01 00540	OTHER ADMINISTRATIVE AND GENERAL	8,815,601	265,612	174,282	251,026	9,506,521
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	3,153,589	427,960	280,806	213,590	4,075,945
7.00 00700	OPERATION OF PLANT	2,177,425	425,858	279,427	75,623	2,958,333
8.00 00800	LAUNDRY & LINEN SERVICE	308,682	8,818	5,786	0	323,286
9.00 00900	HOUSEKEEPING	810,346	18,607	12,209	86,737	927,899
10.00 01000	DIETARY	339,944	51,118	33,541	24,167	448,770
11.00 01100	CAFETERIA	517,173	42,946	28,179	61,444	649,742
13.00 01300	NURSING ADMINISTRATION	1,344,202	11,126	7,300	180,252	1,542,880
14.00 01400	CENTRAL SERVICES & SUPPLY	508,632	29,542	19,384	36,018	593,576
15.00 01500	PHARMACY	1,272,934	34,289	22,499	123,373	1,453,095
16.00 01600	MEDICAL RECORDS & LIBRARY	804,479	40,712	26,713	79,897	951,801
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	4,146,397	618,145	405,596	532,533	5,702,671
31.00 03100	INTENSIVE CARE UNIT	1,342,172	138,171	90,661	171,791	1,742,795
43.00 04300	NURSERY	204,215	13,228	8,679	25,836	251,958
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,473,963	257,279	168,814	187,539	3,087,595
51.00 05100	RECOVERY ROOM	785,516	12,125	7,956	97,792	903,389
52.00 05200	DELIVERY ROOM & LABOR ROOM	486,717	50,589	33,194	61,577	632,077
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,440,627	191,625	125,735	273,196	3,031,183
54.01 05401	ULTRASOUND	0	0	0	0	0
54.02 05402	ONCOLOGY	1,528,870	173,459	113,815	109,771	1,925,915
56.00 05600	RADIOISOTOPE	362,743	7,510	4,928	22,149	397,330
57.00 05700	CT SCAN	532,372	37,140	24,370	39,639	633,521
58.00 05800	MRI	321,985	49,266	32,326	30,939	434,516
60.00 06000	LABORATORY	3,163,839	89,581	58,779	200,663	3,512,862
65.00 06500	RESPIRATORY THERAPY	578,514	44,430	29,153	69,553	721,650
66.00 06600	PHYSICAL THERAPY	1,774,239	133,423	87,546	88,878	2,084,086
67.00 06700	OCCUPATIONAL THERAPY	214,023	0	0	3,342	217,365
68.00 06800	SPEECH PATHOLOGY	30,975	1,470	964	0	33,409
69.00 06900	ELECTROCARDIOLOGY	85,034	735	482	11,140	97,391
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	456,209	0	0	0	456,209
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	2,260,272	0	0	0	2,260,272
73.00 07300	DRUGS CHARGED TO PATIENTS	5,013,304	0	0	0	5,013,304
76.00 03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0
76.01 03610	SLEEP LAB	0	0	0	0	0
76.03 03951	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	603,435	55,968	36,723	79,509	775,635
91.00 09100	EMERGENCY	2,016,135	196,946	129,226	229,806	2,572,113
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	63,608,495	3,441,890	2,258,398	3,367,780	59,919,094
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	54,156	9,039	5,931	4,434	73,560
192.00 19200	PHYSICIANS' PRIVATE OFFICES	138,586	1,889,235	1,239,627	0	3,267,448
192.01 19201	WELLNESS CENTER	0	173,327	113,729	0	287,056
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01 07951	MARKETING	522,136	30,732	20,165	21,110	594,143
194.02 07952	SENIOR CIRCLE	0	0	0	0	0
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	109,937	72,135	0	182,072
194.05 07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00	Cross Foot Adjustments	0	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	64,323,373	5,654,160	3,709,985	3,393,324	64,323,373

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet B
Part I
Date/Time Prepared:
7/27/2016 2:06 pm

Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL 5.01	Subtotal 5A.01	OTHER ADMINISTRATIVE AND GENERAL 5.02	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	
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	00540	OTHER ADMINISTRATIVE AND GENERAL	9,506,521					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	706,863	4,782,808	4,782,808			5.02
7.00	00700	OPERATION OF PLANT	513,043	3,471,376	298,042	3,769,418		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56,065	379,351	32,570	7,353	419,274	8.00
9.00	00900	HOUSEKEEPING	160,919	1,088,818	93,483	15,515	0	9.00
10.00	01000	DIETARY	77,827	526,597	45,212	42,624	0	10.00
11.00	01100	CAFETERIA	112,680	762,422	65,459	35,810	0	11.00
13.00	01300	NURSING ADMINISTRATION	267,571	1,810,451	155,440	9,277	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	102,940	696,516	59,801	24,633	14,511	14.00
15.00	01500	PHARMACY	252,000	1,705,095	146,394	28,592	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	165,064	1,116,865	95,891	33,947	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	988,993	6,691,664	574,542	515,438	94,316	30.00
31.00	03100	INTENSIVE CARE UNIT	302,241	2,045,036	175,581	115,213	25,393	31.00
43.00	04300	NURSERY	43,695	295,653	25,384	11,030	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	535,460	3,623,055	311,065	214,531	92,503	50.00
51.00	05100	RECOVERY ROOM	156,668	1,060,057	91,013	10,111	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	109,617	741,694	63,680	42,183	43,531	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	525,677	3,556,860	305,381	159,786	41,196	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	333,998	2,259,913	194,029	144,638	4,575	54.02
56.00	05600	RADIOISOTOPE	68,906	466,236	40,030	6,263	0	56.00
57.00	05700	CT SCAN	109,867	743,388	63,825	30,969	0	57.00
58.00	05800	MRI	75,355	509,871	43,776	41,080	0	58.00
60.00	06000	LABORATORY	609,211	4,122,073	353,909	74,697	0	60.00
65.00	06500	RESPIRATORY THERAPY	125,151	846,801	72,704	37,048	0	65.00
66.00	06600	PHYSICAL THERAPY	361,428	2,445,514	209,964	111,255	24,744	66.00
67.00	06700	OCCUPATIONAL THERAPY	37,696	255,061	21,899	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,794	39,203	3,366	1,226	0	68.00
69.00	06900	ELECTROCARDIOLOGY	16,890	114,281	9,812	613	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	79,117	535,326	45,961	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	391,983	2,652,255	227,715	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	869,422	5,882,726	505,073	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	134,513	910,148	78,143	46,669	7,255	90.00
91.00	09100	EMERGENCY	446,064	3,018,177	259,132	164,222	50,786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,742,718	59,155,291	4,668,276	1,924,723	398,810	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,757	86,317	7,411	7,537	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	566,651	3,834,099	0	1,575,334	0	192.00
192.01	19201	WELLNESS CENTER	49,782	336,838	28,920	144,528	9,903	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	103,038	697,181	59,858	25,626	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	31,575	213,647	18,343	91,670	0	194.03
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	10,561	194.05
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers		0				201.00
202.00		TOTAL (sum lines 118-201)	9,506,521	64,323,373	4,782,808	3,769,418	419,274	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet B
Part I
Date/Time Prepared:
7/27/2016 2:06 pm

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	1,197,816	638,985				10.00
11.00	01100	24,552	0	884,318			11.00
13.00	01300	20,627	0	47,711	2,028,223		13.00
14.00	01400	5,344	0	19,679	0	829,329	14.00
15.00	01500	14,189	0	26,309	0	21,248	15.00
16.00	01600	16,469	0	36,519	0	2,330	16.00
16.00	01600	19,554	0				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	296,890	346,063	177,638	684,975	49,351	30.00
31.00	03100	66,363	59,890	49,992	220,966	13,723	31.00
43.00	04300	6,353	0	6,551	33,232	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	123,570	12,352	52,883	241,222	147,308	50.00
51.00	05100	5,824	0	27,476	125,785	9,682	51.00
52.00	05200	24,297	61,043	15,621	79,203	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	92,037	0	96,510	0	16,742	54.00
54.01	05401	0	0	0	0	0	54.01
54.02	05402	0	0	0	0	0	54.02
54.02	05402	83,311	0	29,147	141,193	6,246	54.02
56.00	05600	3,607	0	5,463	6,007	245	56.00
57.00	05700	17,838	0	12,757	0	10,005	57.00
58.00	05800	23,662	0	9,521	0	519	58.00
60.00	06000	43,025	0	87,254	0	70,099	60.00
65.00	06500	21,340	0	25,328	89,462	4,661	65.00
66.00	06600	64,082	0	43,707	0	5,352	66.00
67.00	06700	0	0	2,360	0	782	67.00
68.00	06800	706	0	0	0	0	68.00
69.00	06900	353	0	5,066	14,329	587	69.00
71.00	07100	0	0	0	0	65,094	71.00
72.00	07200	0	0	0	0	340,611	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03610	0	0	0	0	0	76.01
76.03	03951	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	26,881	0	29,173	102,268	16,203	90.00
91.00	09100	94,592	0	67,947	295,588	39,932	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		1,095,466	479,348	874,612	2,028,223	820,720	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	4,341	0	2,466	0	3,360	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	83,248	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	14,761	0	7,240	0	5,249	194.01
194.02	07952	0	62,680	0	0	0	194.02
194.03	07953	0	96,957	0	0	0	194.03
194.05	07955	0	0	0	0	0	194.05
200.00							200.00
201.00							201.00
201.00							201.00
202.00		1,197,816	638,985	884,318	2,028,223	829,329	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet B
Part I
Date/Time Prepared:
7/27/2016 2:06 pm

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		15.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	1,944,107					15.00
16.00	01600	0	1,305,106				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	109,978	9,540,855	0	9,540,855	30.00
31.00	03100	0	8,204	2,780,361	0	2,780,361	31.00
43.00	04300	0	3,083	381,286	0	381,286	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	144,212	4,962,701	0	4,962,701	50.00
51.00	05100	0	12,971	1,342,919	0	1,342,919	51.00
52.00	05200	0	7,347	1,078,599	0	1,078,599	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	57,505	4,326,017	0	4,326,017	54.00
54.01	05401	0	0	0	0	0	54.01
54.02	05402	0	28,766	2,891,818	0	2,891,818	54.02
56.00	05600	0	20,644	542,488	0	542,488	56.00
57.00	05700	0	143,953	1,022,735	0	1,022,735	57.00
58.00	05800	0	32,549	660,978	0	660,978	58.00
60.00	06000	0	147,398	4,898,455	0	4,898,455	60.00
65.00	06500	0	43,663	1,141,007	0	1,141,007	65.00
66.00	06600	0	18,521	2,923,139	0	2,923,139	66.00
67.00	06700	0	3,343	283,445	0	283,445	67.00
68.00	06800	0	440	44,941	0	44,941	68.00
69.00	06900	0	7,409	152,450	0	152,450	69.00
71.00	07100	0	38,784	685,165	0	685,165	71.00
72.00	07200	0	40,028	3,260,609	0	3,260,609	72.00
73.00	07300	1,944,107	329,291	8,661,197	0	8,661,197	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03610	0	0	0	0	0	76.01
76.03	03951	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	13,126	1,229,866	0	1,229,866	90.00
91.00	09100	0	93,891	4,084,267	0	4,084,267	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		1,944,107	1,305,106	56,895,298	0	56,895,298	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	111,432	0	111,432	190.00
192.00	19200	0	0	5,409,433	0	5,409,433	192.00
192.01	19201	0	0	603,437	0	603,437	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	809,915	0	809,915	194.01
194.02	07952	0	0	62,680	0	62,680	194.02
194.03	07953	0	0	420,617	0	420,617	194.03
194.05	07955	0	0	10,561	0	10,561	194.05
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,944,107	1,305,106	64,323,373	0	64,323,373	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet B
Part II
Date/Time Prepared:
7/27/2016 2:06 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
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	14,212	9,325	23,537	23,537 4.00
5.01 00540	OTHER ADMINISTRATIVE AND GENERAL	0	265,612	174,282	439,894	1,741 5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	0	427,960	280,806	708,766	1,481 5.02
7.00 00700	OPERATION OF PLANT	0	425,858	279,427	705,285	524 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	8,818	5,786	14,604	0 8.00
9.00 00900	HOUSEKEEPING	0	18,607	12,209	30,816	601 9.00
10.00 01000	DIETARY	0	51,118	33,541	84,659	168 10.00
11.00 01100	CAFETERIA	0	42,946	28,179	71,125	426 11.00
13.00 01300	NURSING ADMINISTRATION	0	11,126	7,300	18,426	1,250 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	29,542	19,384	48,926	250 14.00
15.00 01500	PHARMACY	0	34,289	22,499	56,788	855 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	40,712	26,713	67,425	554 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	618,145	405,596	1,023,741	3,703 30.00
31.00 03100	INTENSIVE CARE UNIT	0	138,171	90,661	228,832	1,191 31.00
43.00 04300	NURSERY	0	13,228	8,679	21,907	179 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	257,279	168,814	426,093	1,300 50.00
51.00 05100	RECOVERY ROOM	0	12,125	7,956	20,081	678 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	50,589	33,194	83,783	427 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	191,625	125,735	317,360	1,894 54.00
54.01 05401	ULTRASOUND	0	0	0	0	0 54.01
54.02 05402	ONCOLOGY	0	173,459	113,815	287,274	761 54.02
56.00 05600	RADIOISOTOPE	0	7,510	4,928	12,438	154 56.00
57.00 05700	CT SCAN	0	37,140	24,370	61,510	275 57.00
58.00 05800	MRI	0	49,266	32,326	81,592	215 58.00
60.00 06000	LABORATORY	0	89,581	58,779	148,360	1,391 60.00
65.00 06500	RESPIRATORY THERAPY	0	44,430	29,153	73,583	482 65.00
66.00 06600	PHYSICAL THERAPY	0	133,423	87,546	220,969	616 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	23 67.00
68.00 06800	SPEECH PATHOLOGY	0	1,470	964	2,434	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	735	482	1,217	77 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0 76.00
76.01 03610	SLEEP LAB	0	0	0	0	0 76.01
76.03 03951	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0 76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	55,968	36,723	92,691	551 90.00
91.00 09100	EMERGENCY	0	196,946	129,226	326,172	1,593 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,441,890	2,258,398	5,700,288	23,360 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,039	5,931	14,970	31 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	1,889,235	1,239,627	3,128,862	0 192.00
192.01 19201	WELLNESS CENTER	0	173,327	113,729	287,056	0 192.01
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
194.01 07951	MARKETING	0	30,732	20,165	50,897	146 194.01
194.02 07952	SENIOR CIRCLE	0	0	0	0	0 194.02
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	109,937	72,135	182,072	0 194.03
194.05 07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.05
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	5,654,160	3,709,985	9,364,145	23,537 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	OTHER 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	00540	OTHER ADMINISTRATIVE AND GENERAL	441,635					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	32,840	743,087				5.02
7.00	00700	OPERATION OF PLANT	23,835	46,305	775,949			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,605	5,060	1,514	23,783		8.00
9.00	00900	HOUSEKEEPING	7,476	14,524	3,194	0	56,611	9.00
10.00	01000	DIETARY	3,616	7,024	8,774	0	1,160	10.00
11.00	01100	CAFETERIA	5,235	10,170	7,372	0	975	11.00
13.00	01300	NURSING ADMINISTRATION	12,431	24,150	1,910	0	253	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,782	9,291	5,071	823	671	14.00
15.00	01500	PHARMACY	11,708	22,744	5,886	0	778	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,669	14,898	6,988	0	924	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	45,921	89,280	106,105	5,349	14,034	30.00
31.00	03100	INTENSIVE CARE UNIT	14,042	27,279	23,717	1,440	3,136	31.00
43.00	04300	NURSERY	2,030	3,944	2,271	0	300	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,877	48,328	44,162	5,247	5,840	50.00
51.00	05100	RECOVERY ROOM	7,279	14,140	2,081	0	275	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,093	9,893	8,684	2,469	1,148	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,422	47,445	32,893	2,337	4,350	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	15,517	30,145	29,774	260	3,937	54.02
56.00	05600	RADIOISOTOPE	3,201	6,219	1,289	0	170	56.00
57.00	05700	CT SCAN	5,104	9,916	6,375	0	843	57.00
58.00	05800	MRI	3,501	6,801	8,456	0	1,118	58.00
60.00	06000	LABORATORY	28,303	54,984	15,377	0	2,033	60.00
65.00	06500	RESPIRATORY THERAPY	5,814	11,295	7,626	0	1,009	65.00
66.00	06600	PHYSICAL THERAPY	16,791	32,621	22,902	1,404	3,029	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,751	3,402	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	269	523	252	0	33	68.00
69.00	06900	ELECTROCARDIOLOGY	785	1,524	126	0	17	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,676	7,141	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,211	35,378	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,392	78,470	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,249	12,140	9,607	412	1,270	90.00
91.00	09100	EMERGENCY	20,724	40,259	33,806	2,881	4,471	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	406,149	725,293	396,212	22,622	51,774	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	593	1,151	1,552	0	205	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,326	0	324,287	0	0	192.00
192.01	19201	WELLNESS CENTER	2,313	4,493	29,752	562	3,934	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	4,787	9,300	5,275	0	698	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	1,467	2,850	18,871	0	0	194.03
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	599	0	194.05
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)	441,635	743,087	775,949	23,783	56,611	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet B
Part II
Date/Time Prepared:
7/27/2016 2:06 pm

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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	105,401					10.00
11.00	01100	0	95,303				11.00
13.00	01300	0	5,142	63,562			13.00
14.00	01400	0	2,121	0	71,935		14.00
15.00	01500	0	2,835	0	1,843	103,437	15.00
16.00	01600	0	3,936	0	202	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	57,084	19,144	21,468	4,281	0	30.00
31.00	03100	9,879	5,388	6,924	1,190	0	31.00
43.00	04300	0	706	1,041	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,037	5,699	7,559	12,777	0	50.00
51.00	05100	0	2,961	3,942	840	0	51.00
52.00	05200	10,069	1,683	2,482	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	10,401	0	1,452	0	54.00
54.01	05401	0	0	0	0	0	54.01
54.02	05402	0	3,141	4,425	542	0	54.02
56.00	05600	0	589	0	21	0	56.00
57.00	05700	0	1,375	0	868	0	57.00
58.00	05800	0	1,026	0	45	0	58.00
60.00	06000	0	9,403	0	6,080	0	60.00
65.00	06500	0	2,730	2,804	404	0	65.00
66.00	06600	0	4,710	0	464	0	66.00
67.00	06700	0	254	0	68	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	546	449	51	0	69.00
71.00	07100	0	0	0	5,646	0	71.00
72.00	07200	0	0	0	29,546	0	72.00
73.00	07300	0	0	0	0	103,437	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03610	0	0	0	0	0	76.01
76.03	03951	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	3,144	3,205	1,405	0	90.00
91.00	09100	0	7,323	9,263	3,464	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		79,069	94,257	63,562	71,189	103,437	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	266	0	291	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	780	0	455	0	194.01
194.02	07952	10,339	0	0	0	0	194.02
194.03	07953	15,993	0	0	0	0	194.03
194.05	07955	0	0	0	0	0	194.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		105,401	95,303	63,562	71,935	103,437	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet B Part II Date/Time Prepared: 7/27/2016 2:06 pm
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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	00540	OTHER ADMINISTRATIVE AND GENERAL				5.01
5.02	00560	OTHER 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	102,596			16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,666	1,398,776	0	1,398,776
31.00	03100	INTENSIVE CARE UNIT	646	323,664	0	323,664
43.00	04300	NURSERY	243	32,621	0	32,621
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,363	595,282	0	595,282
51.00	05100	RECOVERY ROOM	1,022	53,299	0	53,299
52.00	05200	DELIVERY ROOM & LABOR ROOM	579	126,310	0	126,310
53.00	05300	ANESTHESIOLOGY	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,531	447,085	0	447,085
54.01	05401	ULTRASOUND	0	0	0	0
54.02	05402	ONCOLOGY	2,267	378,043	0	378,043
56.00	05600	RADIOISOTOPE	1,627	25,708	0	25,708
57.00	05700	CT SCAN	11,343	97,609	0	97,609
58.00	05800	MRI	2,565	105,319	0	105,319
60.00	06000	LABORATORY	11,614	277,545	0	277,545
65.00	06500	RESPIRATORY THERAPY	3,440	109,187	0	109,187
66.00	06600	PHYSICAL THERAPY	1,459	304,965	0	304,965
67.00	06700	OCCUPATIONAL THERAPY	263	5,761	0	5,761
68.00	06800	SPEECH PATHOLOGY	35	3,546	0	3,546
69.00	06900	ELECTROCARDIOLOGY	584	5,376	0	5,376
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,056	19,519	0	19,519
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,154	86,289	0	86,289
73.00	07300	DRUGS CHARGED TO PATIENTS	25,707	248,006	0	248,006
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0
76.01	03610	SLEEP LAB	0	0	0	0
76.03	03951	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,034	131,708	0	131,708
91.00	09100	EMERGENCY	7,398	457,354	0	457,354
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0	
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	102,596	5,232,972	0	5,232,972
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,059	0	19,059
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,479,475	0	3,479,475
192.01	19201	WELLNESS CENTER	0	328,110	0	328,110
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0
194.01	07951	MARKETING	0	72,338	0	72,338
194.02	07952	SENIOR CIRCLE	0	10,339	0	10,339
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	221,253	0	221,253
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	599	0	599
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	102,596	9,364,145	0	9,364,145

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet B-1

Date/Time Prepared:
7/27/2016 2: 06 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	384,704				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		384,704			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	967	967	22,754,333		4.00
5.01 00540	OTHER ADMINISTRATIVE AND GENERAL	18,072	18,072	1,683,284	-9,506,521	5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	29,118	29,118	1,432,251	0	5.02
7.00 00700	OPERATION OF PLANT	28,975	28,975	507,101	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	600	600	0	0	8.00
9.00 00900	HOUSEKEEPING	1,266	1,266	581,621	0	9.00
10.00 01000	DIETARY	3,478	3,478	162,054	0	10.00
11.00 01100	CAFETERIA	2,922	2,922	412,020	0	11.00
13.00 01300	NURSING ADMINISTRATION	757	757	1,208,697	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,010	2,010	241,523	0	14.00
15.00 01500	PHARMACY	2,333	2,333	827,292	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,770	2,770	535,756	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	42,058	42,058	3,571,006	0	30.00
31.00 03100	INTENSIVE CARE UNIT	9,401	9,401	1,151,963	0	31.00
43.00 04300	NURSERY	900	900	173,247	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	17,505	17,505	1,257,561	0	50.00
51.00 05100	RECOVERY ROOM	825	825	655,755	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,442	3,442	412,908	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	13,038	13,038	1,831,943	0	54.00
54.01 05401	ULTRASOUND	0	0	0	0	54.01
54.02 05402	ONCOLOGY	11,802	11,802	736,081	0	54.02
56.00 05600	RADIOISOTOPE	511	511	148,520	0	56.00
57.00 05700	CT SCAN	2,527	2,527	265,802	0	57.00
58.00 05800	MRI	3,352	3,352	207,467	0	58.00
60.00 06000	LABORATORY	6,095	6,095	1,345,564	0	60.00
65.00 06500	RESPIRATORY THERAPY	3,023	3,023	466,395	0	65.00
66.00 06600	PHYSICAL THERAPY	9,078	9,078	595,980	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	22,407	0	67.00
68.00 06800	SPEECH PATHOLOGY	100	100	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	50	50	74,701	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.01 03610	SLEEP LAB	0	0	0	0	76.01
76.03 03951	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	3,808	3,808	533,153	0	90.00
91.00 09100	EMERGENCY	13,400	13,400	1,540,989	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	234,183	234,183	22,583,041	-9,506,521	50,412,573
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	615	615	29,735	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	128,542	128,542	0	0	192.00
192.01 19201	WELLNESS CENTER	11,793	11,793	0	0	192.01
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	MARKETING	2,091	2,091	141,557	0	194.01
194.02 07952	SENIOR CIRCLE	0	0	0	0	194.02
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	7,480	7,480	0	0	194.03
194.05 07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.05
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)	5,654,160	3,709,985	3,393,324		9,506,521
203.00	Unit cost multiplier (Wkst. B, Part I)	14.697430	9.643739	0.149129		0.173423
204.00	Cost to be allocated (per Wkst. B, Part II)			23,537		441,635
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001034		0.008057

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150133

Period: 03/01/2015 To 02/29/2016

Worksheet B-1

Date/Time Prepared: 7/27/2016 2:06 pm

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5A.02	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	00540	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-4,782,808	55,706,466			5.02
7.00	00700	OPERATION OF PLANT	0	3,471,376	307,572		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	379,351	600	532,612	8.00
9.00	00900	HOUSEKEEPING	0	1,088,818	1,266	0	169,684
10.00	01000	DIETARY	0	526,597	3,478	0	3,478
11.00	01100	CAFETERIA	0	762,422	2,922	0	2,922
13.00	01300	NURSING ADMINISTRATION	0	1,810,451	757	0	757
14.00	01400	CENTRAL SERVICES & SUPPLY	0	696,516	2,010	18,433	2,010
15.00	01500	PHARMACY	0	1,705,095	2,333	0	2,333
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,116,865	2,770	0	2,770
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	6,691,664	42,058	119,812	42,058
31.00	03100	INTENSIVE CARE UNIT	0	2,045,036	9,401	32,257	9,401
43.00	04300	NURSERY	0	295,653	900	0	900
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	3,623,055	17,505	117,508	17,505
51.00	05100	RECOVERY ROOM	0	1,060,057	825	0	825
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	741,694	3,442	55,298	3,442
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,556,860	13,038	52,332	13,038
54.01	05401	ULTRASOUND	0	0	0	0	0
54.02	05402	ONCOLOGY	0	2,259,913	11,802	5,812	11,802
56.00	05600	RADIOISOTOPE	0	466,236	511	0	511
57.00	05700	CT SCAN	0	743,388	2,527	0	2,527
58.00	05800	MRI	0	509,871	3,352	0	3,352
60.00	06000	LABORATORY	0	4,122,073	6,095	0	6,095
65.00	06500	RESPIRATORY THERAPY	0	846,801	3,023	0	3,023
66.00	06600	PHYSICAL THERAPY	0	2,445,514	9,078	31,433	9,078
67.00	06700	OCCUPATIONAL THERAPY	0	255,061	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	39,203	100	0	100
69.00	06900	ELECTROCARDIOLOGY	0	114,281	50	0	50
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	535,326	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,652,255	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,882,726	0	0	0
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0
76.01	03610	SLEEP LAB	0	0	0	0	0
76.03	03951	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	910,148	3,808	9,216	3,808
91.00	09100	EMERGENCY	0	3,018,177	13,400	64,515	13,400
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,782,808	54,372,483	157,051	506,616	155,185
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	86,317	615	0	615
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-3,834,099	0	128,542	0	0
192.01	19201	WELLNESS CENTER	0	336,838	11,793	12,580	11,793
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	MARKETING	0	697,181	2,091	0	2,091
194.02	07952	SENIOR CIRCLE	0	0	0	0	0
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	213,647	7,480	0	0
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	13,416	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)		4,782,808	3,769,418	419,274	1,197,816
203.00		Unit cost multiplier (Wkst. B, Part I)		0.085857	12.255400	0.787203	7.059098
204.00		Cost to be allocated (per Wkst. B, Part II)		743,087	775,949	23,783	56,611
205.00		Unit cost multiplier (Wkst. B, Part II)		0.013339	2.522821	0.044654	0.333626

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet B-1

Date/Time Prepared:
7/27/2016 2:06 pm

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	101,914					11.00
13.00	01300		33,344				13.00
14.00	01400			10,573,759			14.00
15.00	01500				5,503,342		15.00
16.00	01600					5,013,304	16.00
					15,462	0	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	55,195	6,698	3,571,006	327,489	0	30.00
31.00	03100	9,552	1,885	1,151,963	91,062	0	31.00
43.00	04300	0	247	173,247	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,970	1,994	1,257,561	977,515	0	50.00
51.00	05100	0	1,036	655,755	64,251	0	51.00
52.00	05200	9,736	589	412,908	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	3,639	0	111,098	0	54.00
54.01	05401	0	0	0	0	0	54.01
54.02	05402	0	1,099	736,081	41,450	0	54.02
56.00	05600	0	206	0	1,623	0	56.00
57.00	05700	0	481	0	66,395	0	57.00
58.00	05800	0	359	0	3,443	0	58.00
60.00	06000	0	3,290	0	465,165	0	60.00
65.00	06500	0	955	466,395	30,929	0	65.00
66.00	06600	0	1,648	0	35,518	0	66.00
67.00	06700	0	89	0	5,191	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	191	74,701	3,894	0	69.00
71.00	07100	0	0	0	431,956	0	71.00
72.00	07200	0	0	0	2,260,272	0	72.00
73.00	07300	0	0	0	0	5,013,304	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03610	0	0	0	0	0	76.01
76.03	03951	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	1,100	533,153	107,521	0	90.00
91.00	09100	0	2,562	1,540,989	264,982	0	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		76,453	32,978	10,573,759	5,446,217	5,013,304	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	93	0	22,296	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	273	0	34,829	0	194.01
194.02	07952	9,997	0	0	0	0	194.02
194.03	07953	15,464	0	0	0	0	194.03
194.05	07955	0	0	0	0	0	194.05
200.00							200.00
201.00							201.00
202.00		638,985	884,318	2,028,223	829,329	1,944,107	202.00
203.00		6.269845	26.521053	0.191817	0.150696	0.387790	203.00
204.00		105,401	95,303	63,562	71,935	103,437	204.00
205.00		1.034215	2.858175	0.006011	0.013071	0.020633	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet B-1

Date/Time Prepared:
7/27/2016 2:06 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		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	00540	OTHER ADMINISTRATIVE AND GENERAL	5.01
5.02	00560	OTHER 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	16.00
		504,056,357	
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
		42,479,072	
		3,168,605	
		1,190,690	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
54.02	05402	ONCOLOGY	54.02
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	76.00
76.01	03610	SLEEP LAB	76.01
76.03	03951	OTHER ANCILLARY SERVICE COST CENTER	76.03
		55,701,802	
		5,009,956	
		2,837,827	
		0	
		22,211,443	
		0	
		11,110,874	
		7,973,892	
		55,601,884	
		12,572,213	
		56,932,407	
		16,864,998	
		7,153,757	
		1,291,190	
		169,967	
		2,861,819	
		14,980,250	
		15,460,802	
		127,147,438	
		0	
		0	
		0	
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
		5,070,078	
		36,265,393	
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
		504,056,357	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	WELLNESS CENTER	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	MARKETING	194.01
194.02	07952	SENIOR CIRCLE	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	194.03
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	194.05
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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		1,305,106	
		0.002589	
		102,596	
		0.000204	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet C
Part I
Date/Time Prepared:
7/27/2016 2:06 pm

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	9,540,855		9,540,855	0	9,540,855	30.00
31.00	03100 INTENSIVE CARE UNIT	2,780,361		2,780,361	0	2,780,361	31.00
43.00	04300 NURSERY	381,286		381,286	0	381,286	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4,962,701		4,962,701	0	4,962,701	50.00
51.00	05100 RECOVERY ROOM	1,342,919		1,342,919	0	1,342,919	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,078,599		1,078,599	0	1,078,599	52.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,326,017		4,326,017	0	4,326,017	54.00
54.01	05401 ULTRASOUND	0		0	0	0	54.01
54.02	05402 ONCOLOGY	2,891,818		2,891,818	0	2,891,818	54.02
56.00	05600 RADIOISOTOPE	542,488		542,488	0	542,488	56.00
57.00	05700 CT SCAN	1,022,735		1,022,735	0	1,022,735	57.00
58.00	05800 MRI	660,978		660,978	0	660,978	58.00
60.00	06000 LABORATORY	4,898,455		4,898,455	0	4,898,455	60.00
65.00	06500 RESPIRATORY THERAPY	1,141,007	0	1,141,007	0	1,141,007	65.00
66.00	06600 PHYSICAL THERAPY	2,923,139	0	2,923,139	0	2,923,139	66.00
67.00	06700 OCCUPATIONAL THERAPY	283,445	0	283,445	0	283,445	67.00
68.00	06800 SPEECH PATHOLOGY	44,941	0	44,941	0	44,941	68.00
69.00	06900 ELECTROCARDIOLOGY	152,450		152,450	0	152,450	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	685,165		685,165	0	685,165	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,260,609		3,260,609	0	3,260,609	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,661,197		8,661,197	0	8,661,197	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.01	03610 SLEEP LAB	0		0	0	0	76.01
76.03	03951 OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,229,866		1,229,866	0	1,229,866	90.00
91.00	09100 EMERGENCY	4,084,267		4,084,267	0	4,084,267	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,996,397		1,996,397	0	1,996,397	92.00
200.00	Subtotal (see instructions)	58,891,695	0	58,891,695	0	58,891,695	200.00
201.00	Less Observation Beds	1,996,397		1,996,397	0	1,996,397	201.00
202.00	Total (see instructions)	56,895,298	0	56,895,298	0	56,895,298	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet C Part I Date/Time Prepared: 7/27/2016 2:06 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	35,007,283		35,007,283			30.00
31.00 03100 INTENSIVE CARE UNIT	3,168,605		3,168,605			31.00
43.00 04300 NURSERY	1,190,690		1,190,690			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	17,620,619	38,081,183	55,701,802	0.089094	0.000000	50.00
51.00 05100 RECOVERY ROOM	1,631,973	3,377,983	5,009,956	0.268050	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2,609,237	228,590	2,837,827	0.380079	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	3,892,822	18,318,621	22,211,443	0.194765	0.000000	54.00
54.01 05401 ULTRASOUND	0	0	0	0.000000	0.000000	54.01
54.02 05402 ONCOLOGY	88,888	11,021,986	11,110,874	0.260269	0.000000	54.02
56.00 05600 RADIOISOTOPE	833,568	7,140,324	7,973,892	0.068033	0.000000	56.00
57.00 05700 CT SCAN	8,687,297	46,914,587	55,601,884	0.018394	0.000000	57.00
58.00 05800 MRI	1,017,096	11,555,117	12,572,213	0.052575	0.000000	58.00
60.00 06000 LABORATORY	16,020,759	40,911,648	56,932,407	0.086040	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	9,991,825	6,873,173	16,864,998	0.067655	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	1,119,069	6,034,688	7,153,757	0.408616	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	109,903	1,181,287	1,291,190	0.219522	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	79,384	90,583	169,967	0.264410	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	100,000	2,761,819	2,861,819	0.053270	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,885,814	9,094,436	14,980,250	0.045738	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9,835,113	5,625,689	15,460,802	0.210895	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	48,277,011	78,870,427	127,147,438	0.068119	0.000000	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01 03610 SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	500,514	4,569,564	5,070,078	0.242573	0.000000	90.00
91.00 09100 EMERGENCY	7,109,595	29,155,798	36,265,393	0.112622	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2,437,116	5,034,673	7,471,789	0.267191	0.000000	92.00
200.00 Subtotal (see instructions)	177,214,181	326,842,176	504,056,357			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	177,214,181	326,842,176	504,056,357			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet C Part I Date/Time Prepared: 7/27/2016 2:06 pm
	Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
43.00	04300 NURSERY		43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.089094	50.00
51.00	05100 RECOVERY ROOM	0.268050	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.380079	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.194765	54.00
54.01	05401 ULTRASOUND	0.000000	54.01
54.02	05402 ONCOLOGY	0.260269	54.02
56.00	05600 RADIOISOTOPE	0.068033	56.00
57.00	05700 CT SCAN	0.018394	57.00
58.00	05800 MRI	0.052575	58.00
60.00	06000 LABORATORY	0.086040	60.00
65.00	06500 RESPIRATORY THERAPY	0.067655	65.00
66.00	06600 PHYSICAL THERAPY	0.408616	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.219522	67.00
68.00	06800 SPEECH PATHOLOGY	0.264410	68.00
69.00	06900 ELECTROCARDIOLOGY	0.053270	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.045738	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.210895	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.068119	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	76.00
76.01	03610 SLEEP LAB	0.000000	76.01
76.03	03951 OTHER ANCILLARY SERVICE COST CENTER	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.242573	90.00
91.00	09100 EMERGENCY	0.112622	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.267191	92.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet C
Part I
Date/Time Prepared:
7/27/2016 2:06 pm

		Title XIX		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	9,540,855		9,540,855	0	9,540,855	30.00
31.00	03100 INTENSIVE CARE UNIT	2,780,361		2,780,361	0	2,780,361	31.00
43.00	04300 NURSERY	381,286		381,286	0	381,286	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4,962,701		4,962,701	0	4,962,701	50.00
51.00	05100 RECOVERY ROOM	1,342,919		1,342,919	0	1,342,919	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,078,599		1,078,599	0	1,078,599	52.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,326,017		4,326,017	0	4,326,017	54.00
54.01	05401 ULTRASOUND	0		0	0	0	54.01
54.02	05402 ONCOLOGY	2,891,818		2,891,818	0	2,891,818	54.02
56.00	05600 RADIOISOTOPE	542,488		542,488	0	542,488	56.00
57.00	05700 CT SCAN	1,022,735		1,022,735	0	1,022,735	57.00
58.00	05800 MRI	660,978		660,978	0	660,978	58.00
60.00	06000 LABORATORY	4,898,455		4,898,455	0	4,898,455	60.00
65.00	06500 RESPIRATORY THERAPY	1,141,007	0	1,141,007	0	1,141,007	65.00
66.00	06600 PHYSICAL THERAPY	2,923,139	0	2,923,139	0	2,923,139	66.00
67.00	06700 OCCUPATIONAL THERAPY	283,445	0	283,445	0	283,445	67.00
68.00	06800 SPEECH PATHOLOGY	44,941	0	44,941	0	44,941	68.00
69.00	06900 ELECTROCARDIOLOGY	152,450		152,450	0	152,450	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	685,165		685,165	0	685,165	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,260,609		3,260,609	0	3,260,609	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,661,197		8,661,197	0	8,661,197	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.01	03610 SLEEP LAB	0		0	0	0	76.01
76.03	03951 OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,229,866		1,229,866	0	1,229,866	90.00
91.00	09100 EMERGENCY	4,084,267		4,084,267	0	4,084,267	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,996,397		1,996,397	0	1,996,397	92.00
200.00	Subtotal (see instructions)	58,891,695	0	58,891,695	0	58,891,695	200.00
201.00	Less Observation Beds	1,996,397		1,996,397	0	1,996,397	201.00
202.00	Total (see instructions)	56,895,298	0	56,895,298	0	56,895,298	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet C Part I Date/Time Prepared: 7/27/2016 2:06 pm
		Title XIX	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	35,007,283		35,007,283			30.00
31.00 03100 INTENSIVE CARE UNIT	3,168,605		3,168,605			31.00
43.00 04300 NURSERY	1,190,690		1,190,690			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	17,620,619	38,081,183	55,701,802	0.089094	0.000000	50.00
51.00 05100 RECOVERY ROOM	1,631,973	3,377,983	5,009,956	0.268050	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2,609,237	228,590	2,837,827	0.380079	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	3,892,822	18,318,621	22,211,443	0.194765	0.000000	54.00
54.01 05401 ULTRASOUND	0	0	0	0.000000	0.000000	54.01
54.02 05402 ONCOLOGY	88,888	11,021,986	11,110,874	0.260269	0.000000	54.02
56.00 05600 RADIOISOTOPE	833,568	7,140,324	7,973,892	0.068033	0.000000	56.00
57.00 05700 CT SCAN	8,687,297	46,914,587	55,601,884	0.018394	0.000000	57.00
58.00 05800 MRI	1,017,096	11,555,117	12,572,213	0.052575	0.000000	58.00
60.00 06000 LABORATORY	16,020,759	40,911,648	56,932,407	0.086040	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	9,991,825	6,873,173	16,864,998	0.067655	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	1,119,069	6,034,688	7,153,757	0.408616	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	109,903	1,181,287	1,291,190	0.219522	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	79,384	90,583	169,967	0.264410	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	100,000	2,761,819	2,861,819	0.053270	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,885,814	9,094,436	14,980,250	0.045738	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9,835,113	5,625,689	15,460,802	0.210895	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	48,277,011	78,870,427	127,147,438	0.068119	0.000000	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01 03610 SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	500,514	4,569,564	5,070,078	0.242573	0.000000	90.00
91.00 09100 EMERGENCY	7,109,595	29,155,798	36,265,393	0.112622	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2,437,116	5,034,673	7,471,789	0.267191	0.000000	92.00
200.00 Subtotal (see instructions)	177,214,181	326,842,176	504,056,357			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	177,214,181	326,842,176	504,056,357			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet C Part I Date/Time Prepared: 7/27/2016 2:06 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.089094		50.00
51.00	05100 RECOVERY ROOM	0.268050		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.380079		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.194765		54.00
54.01	05401 ULTRASOUND	0.000000		54.01
54.02	05402 ONCOLOGY	0.260269		54.02
56.00	05600 RADIOISOTOPE	0.068033		56.00
57.00	05700 CT SCAN	0.018394		57.00
58.00	05800 MRI	0.052575		58.00
60.00	06000 LABORATORY	0.086040		60.00
65.00	06500 RESPIRATORY THERAPY	0.067655		65.00
66.00	06600 PHYSICAL THERAPY	0.408616		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.219522		67.00
68.00	06800 SPEECH PATHOLOGY	0.264410		68.00
69.00	06900 ELECTROCARDIOLOGY	0.053270		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.045738		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.210895		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.068119		73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000		76.00
76.01	03610 SLEEP LAB	0.000000		76.01
76.03	03951 OTHER ANCILLARY SERVICE COST CENTER	0.000000		76.03
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.242573		90.00
91.00	09100 EMERGENCY	0.112622		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.267191		92.00
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: 150133

Period: From 03/01/2015 To 02/29/2016

Worksheet C Part II Date/Time Prepared: 7/27/2016 2:06 pm

Cost Center Description		Title XIX			Hospital		PPS
		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	4,962,701	595,282	4,367,419	0	0 50.00
51.00	05100	RECOVERY ROOM	1,342,919	53,299	1,289,620	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,078,599	126,310	952,289	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,326,017	447,085	3,878,932	0	0 54.00
54.01	05401	ULTRASOUND	0	0	0	0	0 54.01
54.02	05402	ONCOLOGY	2,891,818	378,043	2,513,775	0	0 54.02
56.00	05600	RADIOISOTOPE	542,488	25,708	516,780	0	0 56.00
57.00	05700	CT SCAN	1,022,735	97,609	925,126	0	0 57.00
58.00	05800	MRI	660,978	105,319	555,659	0	0 58.00
60.00	06000	LABORATORY	4,898,455	277,545	4,620,910	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	1,141,007	109,187	1,031,820	0	0 65.00
66.00	06600	PHYSICAL THERAPY	2,923,139	304,965	2,618,174	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	283,445	5,761	277,684	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	44,941	3,546	41,395	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	152,450	5,376	147,074	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	685,165	19,519	665,646	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,260,609	86,289	3,174,320	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,661,197	248,006	8,413,191	0	0 73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0 76.00
76.01	03610	SLEEP LAB	0	0	0	0	0 76.01
76.03	03951	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0 76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,229,866	131,708	1,098,158	0	0 90.00
91.00	09100	EMERGENCY	4,084,267	457,354	3,626,913	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,996,397	292,690	1,703,707	0	0 92.00
200.00		Subtotal (sum of lines 50 thru 199)	46,189,193	3,770,601	42,418,592	0	0 200.00
201.00		Less Observation Beds	1,996,397	292,690	1,703,707	0	0 201.00
202.00		Total (line 200 minus line 201)	44,192,796	3,477,911	40,714,885	0	0 202.00

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

Provider CCN: 150133

Period: From 03/01/2015 To 02/29/2016

Worksheet C Part II Date/Time Prepared: 7/27/2016 2:06 pm

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)	Title XIX	
					Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4,962,701	55,701,802	0.089094		50.00
51.00	05100 RECOVERY ROOM	1,342,919	5,009,956	0.268050		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,078,599	2,837,827	0.380079		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,326,017	22,211,443	0.194765		54.00
54.01	05401 ULTRASOUND	0	0	0.000000		54.01
54.02	05402 ONCOLOGY	2,891,818	11,110,874	0.260269		54.02
56.00	05600 RADIOISOTOPE	542,488	7,973,892	0.068033		56.00
57.00	05700 CT SCAN	1,022,735	55,601,884	0.018394		57.00
58.00	05800 MRI	660,978	12,572,213	0.052575		58.00
60.00	06000 LABORATORY	4,898,455	56,932,407	0.086040		60.00
65.00	06500 RESPIRATORY THERAPY	1,141,007	16,864,998	0.067655		65.00
66.00	06600 PHYSICAL THERAPY	2,923,139	7,153,757	0.408616		66.00
67.00	06700 OCCUPATIONAL THERAPY	283,445	1,291,190	0.219522		67.00
68.00	06800 SPEECH PATHOLOGY	44,941	169,967	0.264410		68.00
69.00	06900 ELECTROCARDIOLOGY	152,450	2,861,819	0.053270		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	685,165	14,980,250	0.045738		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,260,609	15,460,802	0.210895		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,661,197	127,147,438	0.068119		73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000		76.00
76.01	03610 SLEEP LAB	0	0	0.000000		76.01
76.03	03951 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000		76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	1,229,866	5,070,078	0.242573		90.00
91.00	09100 EMERGENCY	4,084,267	36,265,393	0.112622		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,996,397	7,471,789	0.267191		92.00
200.00	Subtotal (sum of lines 50 thru 199)	46,189,193	464,689,779			200.00
201.00	Less Observation Beds	1,996,397	0			201.00
202.00	Total (line 200 minus line 201)	44,192,796	464,689,779			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet C
Part I
Date/Time Prepared:
7/27/2016 2:06 pm

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	9,540,855		9,540,855	0	9,540,855	30.00
31.00	03100 INTENSIVE CARE UNIT	2,780,361		2,780,361	0	2,780,361	31.00
43.00	04300 NURSERY	381,286		381,286	0	381,286	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4,962,701		4,962,701	0	4,962,701	50.00
51.00	05100 RECOVERY ROOM	1,342,919		1,342,919	0	1,342,919	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,078,599		1,078,599	0	1,078,599	52.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,326,017		4,326,017	0	4,326,017	54.00
54.01	05401 ULTRASOUND	0		0	0	0	54.01
54.02	05402 ONCOLOGY	2,891,818		2,891,818	0	2,891,818	54.02
56.00	05600 RADIOISOTOPE	542,488		542,488	0	542,488	56.00
57.00	05700 CT SCAN	1,022,735		1,022,735	0	1,022,735	57.00
58.00	05800 MRI	660,978		660,978	0	660,978	58.00
60.00	06000 LABORATORY	4,898,455		4,898,455	0	4,898,455	60.00
65.00	06500 RESPIRATORY THERAPY	1,141,007	0	1,141,007	0	1,141,007	65.00
66.00	06600 PHYSICAL THERAPY	2,923,139	0	2,923,139	0	2,923,139	66.00
67.00	06700 OCCUPATIONAL THERAPY	283,445	0	283,445	0	283,445	67.00
68.00	06800 SPEECH PATHOLOGY	44,941	0	44,941	0	44,941	68.00
69.00	06900 ELECTROCARDIOLOGY	152,450		152,450	0	152,450	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	685,165		685,165	0	685,165	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,260,609		3,260,609	0	3,260,609	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,661,197		8,661,197	0	8,661,197	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.01	03610 SLEEP LAB	0		0	0	0	76.01
76.03	03951 OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,229,866		1,229,866	0	1,229,866	90.00
91.00	09100 EMERGENCY	4,084,267		4,084,267	0	4,084,267	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,996,397		1,996,397	0	1,996,397	92.00
200.00	Subtotal (see instructions)	58,891,695	0	58,891,695	0	58,891,695	200.00
201.00	Less Observation Beds	1,996,397		1,996,397	0	1,996,397	201.00
202.00	Total (see instructions)	56,895,298	0	56,895,298	0	56,895,298	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet C Part I Date/Time Prepared: 7/27/2016 2:06 pm
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Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	35,007,283		35,007,283			30.00
31.00 03100 INTENSIVE CARE UNIT	3,168,605		3,168,605			31.00
43.00 04300 NURSERY	1,190,690		1,190,690			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	17,620,619	38,081,183	55,701,802	0.089094	0.000000	50.00
51.00 05100 RECOVERY ROOM	1,631,973	3,377,983	5,009,956	0.268050	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2,609,237	228,590	2,837,827	0.380079	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	3,892,822	18,318,621	22,211,443	0.194765	0.000000	54.00
54.01 05401 ULTRASOUND	0	0	0	0.000000	0.000000	54.01
54.02 05402 ONCOLOGY	88,888	11,021,986	11,110,874	0.260269	0.000000	54.02
56.00 05600 RADIOISOTOPE	833,568	7,140,324	7,973,892	0.068033	0.000000	56.00
57.00 05700 CT SCAN	8,687,297	46,914,587	55,601,884	0.018394	0.000000	57.00
58.00 05800 MRI	1,017,096	11,555,117	12,572,213	0.052575	0.000000	58.00
60.00 06000 LABORATORY	16,020,759	40,911,648	56,932,407	0.086040	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	9,991,825	6,873,173	16,864,998	0.067655	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	1,119,069	6,034,688	7,153,757	0.408616	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	109,903	1,181,287	1,291,190	0.219522	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	79,384	90,583	169,967	0.264410	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	100,000	2,761,819	2,861,819	0.053270	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,885,814	9,094,436	14,980,250	0.045738	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9,835,113	5,625,689	15,460,802	0.210895	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	48,277,011	78,870,427	127,147,438	0.068119	0.000000	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01 03610 SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	500,514	4,569,564	5,070,078	0.242573	0.000000	90.00
91.00 09100 EMERGENCY	7,109,595	29,155,798	36,265,393	0.112622	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2,437,116	5,034,673	7,471,789	0.267191	0.000000	92.00
200.00 Subtotal (see instructions)	177,214,181	326,842,176	504,056,357			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	177,214,181	326,842,176	504,056,357			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet C Part I Date/Time Prepared: 7/27/2016 2:06 pm
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Cost Center Description		PPS Inpatient Ratio	Title V	Hospital	Cost
		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
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401 ULTRASOUND	0.000000			54.01
54.02	05402 ONCOLOGY	0.000000			54.02
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MRI	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000			76.00
76.01	03610 SLEEP LAB	0.000000			76.01
76.03	03951 OTHER ANCILLARY SERVICE COST CENTER	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150133		Period: From 03/01/2015 To 02/29/2016		Worksheet D Part I Date/Time Prepared: 7/27/2016 2:06 pm	
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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,398,776	0	1,398,776	12,478	112.10	30.00
31.00	INTENSIVE CARE UNIT	323,664		323,664	1,558	207.74	31.00
43.00	NURSERY	32,621		32,621	1,011	32.27	43.00
200.00	Total (Lines 30-199)	1,755,061		1,755,061	15,047		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	3,726	417,685				
31.00	INTENSIVE CARE UNIT	681	141,471				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	4,407	559,156				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part II Date/Time Prepared: 7/27/2016 2:06 pm
		Title XVIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	595,282	55,701,802	0.010687	4,817,372	51,483	50.00
51.00	05100 RECOVERY ROOM	53,299	5,009,956	0.010639	434,952	4,627	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	126,310	2,837,827	0.044509	6,451	287	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	447,085	22,211,443	0.020129	3,251,192	65,443	54.00
54.01	05401 ULTRASOUND	0	0	0.000000	0	0	54.01
54.02	05402 ONCOLOGY	378,043	11,110,874	0.034025	50,399	1,715	54.02
56.00	05600 RADIOISOTOPE	25,708	7,973,892	0.003224	349,873	1,128	56.00
57.00	05700 CT SCAN	97,609	55,601,884	0.001755	4,526,980	7,945	57.00
58.00	05800 MRI	105,319	12,572,213	0.008377	357,552	2,995	58.00
60.00	06000 LABORATORY	277,545	56,932,407	0.004875	7,196,513	35,083	60.00
65.00	06500 RESPIRATORY THERAPY	109,187	16,864,998	0.006474	4,598,108	29,768	65.00
66.00	06600 PHYSICAL THERAPY	304,965	7,153,757	0.042630	466,383	19,882	66.00
67.00	06700 OCCUPATIONAL THERAPY	5,761	1,291,190	0.004462	54,262	242	67.00
68.00	06800 SPEECH PATHOLOGY	3,546	169,967	0.020863	43,531	908	68.00
69.00	06900 ELECTROCARDIOLOGY	5,376	2,861,819	0.001879	46,218	87	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	19,519	14,980,250	0.001303	1,852,751	2,414	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	86,289	15,460,802	0.005581	3,366,293	18,787	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	248,006	127,147,438	0.001951	18,294,765	35,693	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.01	03610 SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	131,708	5,070,078	0.025978	122,090	3,172	90.00
91.00	09100 EMERGENCY	457,354	36,265,393	0.012611	2,791,807	35,207	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	292,690	7,471,789	0.039173	884,462	34,647	92.00
200.00	Total (lines 50-199)	3,770,601	464,689,779		53,511,954	351,513	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150133		Period: From 03/01/2015 To 02/29/2016		Worksheet D Part III Date/Time Prepared: 7/27/2016 2:06 pm	
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	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	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	12,478	0.00	3,726	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,558	0.00	681	0		31.00
43.00	04300	NURSERY	1,011	0.00	0	0		43.00
200.00		Total (lines 30-199)	15,047		4,407	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part IV Date/Time Prepared: 7/27/2016 2:06 pm
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Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
54.01	05401	ULTRASOUND	0	0	0	0	0 54.01
54.02	05402	ONCOLOGY	0	0	0	0	0 54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0 76.00
76.01	03610	SLEEP LAB	0	0	0	0	0 76.01
76.03	03951	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0 76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
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: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part IV Date/Time Prepared: 7/27/2016 2:06 pm
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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	55,701,802	0.000000	0.000000	4,817,372	50.00
51.00	05100 RECOVERY ROOM	0	5,009,956	0.000000	0.000000	434,952	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2,837,827	0.000000	0.000000	6,451	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	22,211,443	0.000000	0.000000	3,251,192	54.00
54.01	05401 ULTRASOUND	0	0	0.000000	0.000000	0	54.01
54.02	05402 ONCOLOGY	0	11,110,874	0.000000	0.000000	50,399	54.02
56.00	05600 RADIOISOTOPE	0	7,973,892	0.000000	0.000000	349,873	56.00
57.00	05700 CT SCAN	0	55,601,884	0.000000	0.000000	4,526,980	57.00
58.00	05800 MRI	0	12,572,213	0.000000	0.000000	357,552	58.00
60.00	06000 LABORATORY	0	56,932,407	0.000000	0.000000	7,196,513	60.00
65.00	06500 RESPIRATORY THERAPY	0	16,864,998	0.000000	0.000000	4,598,108	65.00
66.00	06600 PHYSICAL THERAPY	0	7,153,757	0.000000	0.000000	466,383	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,291,190	0.000000	0.000000	54,262	67.00
68.00	06800 SPEECH PATHOLOGY	0	169,967	0.000000	0.000000	43,531	68.00
69.00	06900 ELECTROCARDIOLOGY	0	2,861,819	0.000000	0.000000	46,218	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,980,250	0.000000	0.000000	1,852,751	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	15,460,802	0.000000	0.000000	3,366,293	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	127,147,438	0.000000	0.000000	18,294,765	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.01	03610 SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.03	03951 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	5,070,078	0.000000	0.000000	122,090	90.00
91.00	09100 EMERGENCY	0	36,265,393	0.000000	0.000000	2,791,807	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7,471,789	0.000000	0.000000	884,462	92.00
200.00	Total (lines 50-199)	0	464,689,779			53,511,954	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part IV Date/Time Prepared: 7/27/2016 2:06 pm
Title XVIII		Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	5,108,985	0	50.00
51.00	05100 RECOVERY ROOM	0	366,381	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	216	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,586,875	0	54.00
54.01	05401 ULTRASOUND	0	0	0	54.01
54.02	05402 ONCOLOGY	0	2,634,270	0	54.02
56.00	05600 RADIOISOTOPE	0	1,826,434	0	56.00
57.00	05700 CT SCAN	0	7,336,884	0	57.00
58.00	05800 MRI	0	2,103,381	0	58.00
60.00	06000 LABORATORY	0	3,902,763	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,342,066	0	65.00
66.00	06600 PHYSICAL THERAPY	0	5,533	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,364	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	419	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	768,549	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,046,292	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	595,369	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	17,965,960	0	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	76.00
76.01	03610 SLEEP LAB	0	0	0	76.01
76.03	03951 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	700,486	0	90.00
91.00	09100 EMERGENCY	0	3,829,658	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1,003,393	0	92.00
200.00	Total (Lines 50-199)	0	56,125,278	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part V Date/Time Prepared: 7/27/2016 2:06 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.089094	5,108,985	0	0	455,180	50.00
51.00	05100	RECOVERY ROOM	0.268050	366,381	0	0	98,208	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.380079	216	0	0	82	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194765	5,586,875	0	0	1,088,128	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0.260269	2,634,270	0	0	685,619	54.02
56.00	05600	RADIOISOTOPE	0.068033	1,826,434	0	0	124,258	56.00
57.00	05700	CT SCAN	0.018394	7,336,884	0	0	134,955	57.00
58.00	05800	MRI	0.052575	2,103,381	0	0	110,585	58.00
60.00	06000	LABORATORY	0.086040	3,902,763	3,656	0	335,794	60.00
65.00	06500	RESPIRATORY THERAPY	0.067655	1,342,066	292	0	90,797	65.00
66.00	06600	PHYSICAL THERAPY	0.408616	5,533	0	0	2,261	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.219522	1,364	0	0	299	67.00
68.00	06800	SPEECH PATHOLOGY	0.264410	419	0	0	111	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053270	768,549	0	0	40,941	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045738	1,046,292	0	0	47,855	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.210895	595,369	0	0	125,560	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.068119	17,965,960	0	34,640	1,223,823	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.242573	700,486	0	0	169,919	90.00
91.00	09100	EMERGENCY	0.112622	3,829,658	0	0	431,304	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.267191	1,003,393	0	0	268,098	92.00
200.00		Subtotal (see instructions)		56,125,278	3,948	34,640	5,433,777	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		56,125,278	3,948	34,640	5,433,777	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part V Date/Time Prepared: 7/27/2016 2:06 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 ULTRASOUND	0	0		54.01
54.02 05402 ONCOLOGY	0	0		54.02
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	315	0		60.00
65.00 06500 RESPIRATORY THERAPY	20	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	2,360		73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.01 03610 SLEEP LAB	0	0		76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0	0		76.03
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	335	2,360		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	335	2,360		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150133		Period: From 03/01/2015 To 02/29/2016		Worksheet D Part I Date/Time Prepared: 7/27/2016 2:06 pm	
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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,398,776	0	1,398,776	12,478	112.10	30.00
31.00	INTENSIVE CARE UNIT	323,664		323,664	1,558	207.74	31.00
43.00	NURSERY	32,621		32,621	1,011	32.27	43.00
200.00	Total (Lines 30-199)	1,755,061		1,755,061	15,047		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	1,290	144,609				
31.00	INTENSIVE CARE UNIT	247	51,312				
43.00	NURSERY	483	15,586				
200.00	Total (Lines 30-199)	2,020	211,507				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part II Date/Time Prepared: 7/27/2016 2:06 pm
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Cost Center Description		Title XIX				Hospital		PPS
		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	595,282	55,701,802	0.010687	312,027	3,335	50.00
51.00	05100	RECOVERY ROOM	53,299	5,009,956	0.010639	29,182	310	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	126,310	2,837,827	0.044509	87,227	3,882	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	447,085	22,211,443	0.020129	102,690	2,067	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
54.02	05402	ONCOLOGY	378,043	11,110,874	0.034025	0	0	54.02
56.00	05600	RADIOISOTOPE	25,708	7,973,892	0.003224	18,048	58	56.00
57.00	05700	CT SCAN	97,609	55,601,884	0.001755	187,603	329	57.00
58.00	05800	MRI	105,319	12,572,213	0.008377	29,245	245	58.00
60.00	06000	LABORATORY	277,545	56,932,407	0.004875	394,495	1,923	60.00
65.00	06500	RESPIRATORY THERAPY	109,187	16,864,998	0.006474	229,277	1,484	65.00
66.00	06600	PHYSICAL THERAPY	304,965	7,153,757	0.042630	21,438	914	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,761	1,291,190	0.004462	543	2	67.00
68.00	06800	SPEECH PATHOLOGY	3,546	169,967	0.020863	390	8	68.00
69.00	06900	ELECTROCARDIOLOGY	5,376	2,861,819	0.001879	3,508	7	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,519	14,980,250	0.001303	99,382	129	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,289	15,460,802	0.005581	114,697	640	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	248,006	127,147,438	0.001951	1,081,278	2,110	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	131,708	5,070,078	0.025978	8,962	233	90.00
91.00	09100	EMERGENCY	457,354	36,265,393	0.012611	163,838	2,066	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	292,690	7,471,789	0.039173	48,525	1,901	92.00
200.00		Total (lines 50-199)	3,770,601	464,689,779		2,932,355	21,643	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150133		Period: From 03/01/2015 To 02/29/2016		Worksheet D Part III Date/Time Prepared: 7/27/2016 2:06 pm	
Cost Center Description			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	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	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	12,478	0.00	1,290	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,558	0.00	247	0		31.00
43.00	04300	NURSERY	1,011	0.00	483	0		43.00
200.00		Total (lines 30-199)	15,047		2,020	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part IV Date/Time Prepared: 7/27/2016 2:06 pm
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Cost Center Description	Title XIX				Hospital	PPS
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 05401 ULTRASOUND	0	0	0	0	0	54.01
54.02 05402 ONCOLOGY	0	0	0	0	0	54.02
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01 03610 SLEEP LAB	0	0	0	0	0	76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
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: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part IV Date/Time Prepared: 7/27/2016 2:06 pm
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Cost Center Description	Title XIX			Hospital		PPS		
	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	55,701,802	0.000000	0.000000	312,027	50.00
51.00	05100	RECOVERY ROOM	0	5,009,956	0.000000	0.000000	29,182	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,837,827	0.000000	0.000000	87,227	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,211,443	0.000000	0.000000	102,690	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
54.02	05402	ONCOLOGY	0	11,110,874	0.000000	0.000000	0	54.02
56.00	05600	RADIOISOTOPE	0	7,973,892	0.000000	0.000000	18,048	56.00
57.00	05700	CT SCAN	0	55,601,884	0.000000	0.000000	187,603	57.00
58.00	05800	MRI	0	12,572,213	0.000000	0.000000	29,245	58.00
60.00	06000	LABORATORY	0	56,932,407	0.000000	0.000000	394,495	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,864,998	0.000000	0.000000	229,277	65.00
66.00	06600	PHYSICAL THERAPY	0	7,153,757	0.000000	0.000000	21,438	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,291,190	0.000000	0.000000	543	67.00
68.00	06800	SPEECH PATHOLOGY	0	169,967	0.000000	0.000000	390	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,861,819	0.000000	0.000000	3,508	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,980,250	0.000000	0.000000	99,382	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,460,802	0.000000	0.000000	114,697	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	127,147,438	0.000000	0.000000	1,081,278	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.03	03951	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	5,070,078	0.000000	0.000000	8,962	90.00
91.00	09100	EMERGENCY	0	36,265,393	0.000000	0.000000	163,838	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,471,789	0.000000	0.000000	48,525	92.00
200.00		Total (lines 50-199)	0	464,689,779			2,932,355	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part IV Date/Time Prepared: 7/27/2016 2:06 pm
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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		
Title XIX Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401 ULTRASOUND	0	0	0		54.01
54.02	05402 ONCOLOGY	0	0	0		54.02
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MRI	0	0	0		58.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0		76.00
76.01	03610 SLEEP LAB	0	0	0		76.01
76.03	03951 OTHER ANCILLARY SERVICE COST CENTER	0	0	0		76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part V Date/Time Prepared: 7/27/2016 2:06 pm
		Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.089094	0	0	461,017	0	50.00
51.00 05100 RECOVERY ROOM	0.268050	0	0	52,637	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.380079	0	0	16,332	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.194765	0	0	557,636	0	54.00
54.01 05401 ULTRASOUND	0.000000	0	0	0	0	54.01
54.02 05402 ONCOLOGY	0.260269	0	0	126,462	0	54.02
56.00 05600 RADIOISOTOPE	0.068033	0	0	75,469	0	56.00
57.00 05700 CT SCAN	0.018394	0	0	1,129,797	0	57.00
58.00 05800 MRI	0.052575	0	0	174,092	0	58.00
60.00 06000 LABORATORY	0.086040	0	0	939,146	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.067655	0	0	146,065	0	65.00
66.00 06600 PHYSICAL THERAPY	0.408616	0	0	86,753	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.219522	0	0	30,050	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.264410	0	0	4,832	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.053270	0	0	34,825	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.045738	0	0	157,159	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.210895	0	0	65,002	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.068119	0	0	1,249,762	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.01 03610 SLEEP LAB	0.000000	0	0	0	0	76.01
76.03 03951 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.242573	0	0	80,969	0	90.00
91.00 09100 EMERGENCY	0.112622	0	0	1,054,104	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.267191	0	0	121,420	0	92.00
200.00 Subtotal (see instructions)		0	0	6,563,529	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	6,563,529	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part V Date/Time Prepared: 7/27/2016 2:06 pm
		Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	41,074	50.00
51.00	05100 RECOVERY ROOM	0	14,109	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	6,207	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	108,608	54.00
54.01	05401 ULTRASOUND	0	0	54.01
54.02	05402 ONCOLOGY	0	32,914	54.02
56.00	05600 RADIOISOTOPE	0	5,134	56.00
57.00	05700 CT SCAN	0	20,781	57.00
58.00	05800 MRI	0	9,153	58.00
60.00	06000 LABORATORY	0	80,804	60.00
65.00	06500 RESPIRATORY THERAPY	0	9,882	65.00
66.00	06600 PHYSICAL THERAPY	0	35,449	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	6,597	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,278	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,855	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,188	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	13,709	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	85,133	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.01	03610 SLEEP LAB	0	0	76.01
76.03	03951 OTHER ANCILLARY SERVICE COST CENTER	0	0	76.03
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	19,641	90.00
91.00	09100 EMERGENCY	0	118,715	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	32,442	92.00
200.00	Subtotal (see instructions)	0	650,673	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	650,673	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D-1 Date/Time Prepared: 7/27/2016 2:06 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,478	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,478	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)		9,867	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,726	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,540,855	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)		9,540,855	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)		9,540,855	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)		764.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,848,937	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,848,937	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150133		Period: From 03/01/2015 To 02/29/2016		Worksheet D-1 Date/Time Prepared: 7/27/2016 2:06 pm	
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)	
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	
42.00	Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	2,780,361	1,558	1,784.57	681	1,215,292	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,088,425	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					9,152,654	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)					559,156	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					351,513	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					910,669	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,241,985	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,611	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					764.61	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,996,397	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150133		Period: From 03/01/2015 To 02/29/2016		Worksheet D-1 Date/Time Prepared: 7/27/2016 2:06 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,398,776	9,540,855	0.146609	1,996,397	292,690	90.00
91.00	Nursing School cost	0	9,540,855	0.000000	1,996,397	0	91.00
92.00	Allied health cost	0	9,540,855	0.000000	1,996,397	0	92.00
93.00	All other Medical Education	0	9,540,855	0.000000	1,996,397	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D-1 Date/Time Prepared: 7/27/2016 2:06 pm
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,478	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,478	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)		9,867	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,290	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,011	15.00
16.00	Nursery days (title V or XIX only)		483	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,540,855	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)		9,540,855	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)		9,540,855	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)		764.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		986,347	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)		986,347	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D-1 Date/Time Prepared: 7/27/2016 2:06 pm		
Cost Center Description			Title XIX	Hospital	PPS		
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	381,286	1,011	377.14	483	182,159	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	2,780,361	1,558	1,784.57	247	440,789	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					289,597	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,898,892	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)					211,507	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					21,643	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					233,150	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,665,742	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,611	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					764.61	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,996,397	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150133		Period: From 03/01/2015 To 02/29/2016		Worksheet D-1 Date/Time Prepared: 7/27/2016 2:06 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,398,776	9,540,855	0.146609	1,996,397	292,690	90.00
91.00	Nursing School cost	0	9,540,855	0.000000	1,996,397	0	91.00
92.00	Allied health cost	0	9,540,855	0.000000	1,996,397	0	92.00
93.00	All other Medical Education	0	9,540,855	0.000000	1,996,397	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D-3 Date/Time Prepared: 7/27/2016 2:06 pm	
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		8,421,848	30.00
31.00	03100	INTENSIVE CARE UNIT		2,366,200	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.089094	4,817,372	429,199 50.00
51.00	05100	RECOVERY ROOM	0.268050	434,952	116,589 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.380079	6,451	2,452 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194765	3,251,192	633,218 54.00
54.01	05401	ULTRASOUND	0.000000	0	0 54.01
54.02	05402	ONCOLOGY	0.260269	50,399	13,117 54.02
56.00	05600	RADIOISOTOPE	0.068033	349,873	23,803 56.00
57.00	05700	CT SCAN	0.018394	4,526,980	83,269 57.00
58.00	05800	MRI	0.052575	357,552	18,798 58.00
60.00	06000	LABORATORY	0.086040	7,196,513	619,188 60.00
65.00	06500	RESPIRATORY THERAPY	0.067655	4,598,108	311,085 65.00
66.00	06600	PHYSICAL THERAPY	0.408616	466,383	190,572 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.219522	54,262	11,912 67.00
68.00	06800	SPEECH PATHOLOGY	0.264410	43,531	11,510 68.00
69.00	06900	ELECTROCARDIOLOGY	0.053270	46,218	2,462 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045738	1,852,751	84,741 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.210895	3,366,293	709,934 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.068119	18,294,765	1,246,221 73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0 76.00
76.01	03610	SLEEP LAB	0.000000	0	0 76.01
76.03	03951	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0 76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.242573	122,090	29,616 90.00
91.00	09100	EMERGENCY	0.112622	2,791,807	314,419 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.267191	884,462	236,320 92.00
200.00		Total (sum of lines 50-94 and 96-98)		53,511,954	5,088,425 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		53,511,954	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet D-3 Date/Time Prepared: 7/27/2016 2:06 pm	
Cost Center Description		Title XIX	Hospital	PPS	
		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		392,456	30.00
31.00	03100	INTENSIVE CARE UNIT		170,348	31.00
43.00	04300	NURSERY		105,665	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.089094	312,027	50.00
51.00	05100	RECOVERY ROOM	0.268050	29,182	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.380079	87,227	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194765	102,690	54.00
54.01	05401	ULTRASOUND	0.000000	0	54.01
54.02	05402	ONCOLOGY	0.260269	0	54.02
56.00	05600	RADIOISOTOPE	0.068033	18,048	56.00
57.00	05700	CT SCAN	0.018394	187,603	57.00
58.00	05800	MRI	0.052575	29,245	58.00
60.00	06000	LABORATORY	0.086040	394,495	60.00
65.00	06500	RESPIRATORY THERAPY	0.067655	229,277	65.00
66.00	06600	PHYSICAL THERAPY	0.408616	21,438	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.219522	543	67.00
68.00	06800	SPEECH PATHOLOGY	0.264410	390	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053270	3,508	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045738	99,382	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.210895	114,697	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.068119	1,081,278	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	76.01
76.03	03951	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.242573	8,962	90.00
91.00	09100	EMERGENCY	0.112622	163,838	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.267191	48,525	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,932,355	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		2,932,355	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet E Part A Date/Time Prepared: 7/27/2016 2:06 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		4,020,668	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,288,551	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		89,411	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		4,290,853	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		64.87	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.12	30.00
31.00	Percentage of Medicaid patient days (see instructions)		17.86	31.00
32.00	Sum of lines 30 and 31		19.98	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.74	33.00
34.00	Disproportionate share adjustment (see instructions)		104,888	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet E Part A Date/Time Prepared: 7/27/2016 2:06 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000071948	0.000070003	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	550,233	448,447	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	322,602	186,240	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	508,842		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	8,012,360		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		8,012,360	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		595,480	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		8,607,840	59.00
60.00	Primary payer payments		10,978	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		8,596,862	61.00
62.00	Deductibles billed to program beneficiaries		1,107,824	62.00
63.00	Coinurance billed to program beneficiaries		3,822	63.00
64.00	Allowable bad debts (see instructions)		117,123	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		76,130	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		19,903	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		7,561,346	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		18,870	70.93
70.94	HRR adjustment amount (see instructions)		-73,025	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet E Part A Date/Time Prepared: 7/27/2016 2:06 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,507,191		71.00
71.01	Sequestration adjustment (see instructions)		150,144		71.01
72.00	Interim payments		7,291,534		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		65,513		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		818,016		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0		100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0		102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0		104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet E Part B Date/Time Prepared: 7/27/2016 2:06 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			2,695 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			5,433,777 2.00
3.00	PPS payments			5,691,735 3.00
4.00	Outlier payment (see instructions)			4,897 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)			2,695 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			38,588 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)			38,588 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 charge basis 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)			38,588 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			35,893 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)			2,695 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)			5,696,632 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			58 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,238,490 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)			4,460,779 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)			4,460,779 30.00
31.00	Primary payer payments			778 31.00
32.00	Subtotal (line 30 minus line 31)			4,460,001 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)			235,980 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			153,387 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			151,224 36.00
37.00	Subtotal (see instructions)			4,613,388 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)			4,613,388 40.00
40.01	Sequestration adjustment (see instructions)			92,268 40.01
41.00	Interim payments			4,443,783 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			77,337 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: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet E-1
Part I
Date/Time Prepared:
7/27/2016 2:06 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		7,291,534		4,443,783	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,291,534		4,443,783	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		65,513		77,337	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		7,357,047		4,521,120	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: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet E-1
Part II
Date/Time Prepared:
7/27/2016 2:06 pm

Title XVIII		Hospital	PPS
			1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	3,703	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	4,407	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	2,530	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	11,425	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	504,056,357	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,167,322	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)	382,018	8.00
9.00	Sequestration adjustment amount (see instructions)	7,640	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	374,378	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)	358,295	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)	16,083	32.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet G

Date/Time Prepared:
7/27/2016 2:06 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-268,396	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	25,938,993	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,793,845	0	0	0	6.00
7.00	Inventory	1,816,752	0	0	0	7.00
8.00	Prepaid expenses	733,748	0	0	0	8.00
9.00	Other current assets	451,085	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)	20,878,337	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,768,505	0	0	0	12.00
13.00	Land improvements	1,160,268	0	0	0	13.00
14.00	Accumulated depreciation	-687,684	0	0	0	14.00
15.00	Buildings	35,723,757	0	0	0	15.00
16.00	Accumulated depreciation	-8,647,402	0	0	0	16.00
17.00	Leasehold improvements	14,400,835	0	0	0	17.00
18.00	Accumulated depreciation	-4,329,304	0	0	0	18.00
19.00	Fixed equipment	2,411,781	0	0	0	19.00
20.00	Accumulated depreciation	-1,375,600	0	0	0	20.00
21.00	Automobiles and trucks	110,970	0	0	0	21.00
22.00	Accumulated depreciation	-93,329	0	0	0	22.00
23.00	Major movable equipment	18,209,912	0	0	0	23.00
24.00	Accumulated depreciation	-14,224,581	0	0	0	24.00
25.00	Minor equipment depreciable	5,063,654	0	0	0	25.00
26.00	Accumulated depreciation	-3,704,350	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)	46,787,432	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,078,708	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,078,708	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	70,744,477	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,631,722	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,716,945	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	33,340	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	-300,393,033	0	0	0	43.00
44.00	Other current liabilities	1,736,851	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-293,274,175	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	166,660	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,086,435	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,253,095	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-291,021,080	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	361,765,557				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)	361,765,557	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	70,744,477	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet G-1

Date/Time Prepared:
7/27/2016 2:06 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		319,077,004		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		42,688,553			2.00
3.00	Total (sum of line 1 and line 2)		361,765,557		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		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)		361,765,557		0	11.00
12.00		0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		361,765,557		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			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: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet G-2
Parts I & II
Date/Time Prepared:
7/27/2016 2:06 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	36,197,973		36,197,973	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)	36,197,973		36,197,973	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,168,605		3,168,605	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)	3,168,605		3,168,605	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	39,366,578		39,366,578	17.00
18.00	Ancillary services	127,800,378	288,082,141	415,882,519	18.00
19.00	Outpatient services	10,047,225	38,760,035	48,807,260	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	177,214,181	326,842,176	504,056,357	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		66,386,473		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)		66,386,473		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150133

Period:
From 03/01/2015
To 02/29/2016

Worksheet G-3

Date/Time Prepared:
7/27/2016 2:06 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	504,056,357	1.00
2.00	Less contractual allowances and discounts on patients' accounts	395,976,786	2.00
3.00	Net patient revenues (line 1 minus line 2)	108,079,571	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	66,386,473	4.00
5.00	Net income from service to patients (line 3 minus line 4)	41,693,098	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	995,455	24.00
25.00	Total other income (sum of lines 6-24)	995,455	25.00
26.00	Total (line 5 plus line 25)	42,688,553	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)	42,688,553	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150133	Period: From 03/01/2015 To 02/29/2016	Worksheet L Parts I-III Date/Time Prepared: 7/27/2016 2:06 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		579,985	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		15,495	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		31.22	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		595,480	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00