

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: 150097 Period: From 01/01/2015 To 12/31/2015 Worksheet 5 Parts I-III Date/Time Prepared: 4/28/2016 3:25 pm

PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 4/28/2016 Time: 3:25 pm
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only 5. 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. Initial Report for this Provider CCN 9. Final Report for this Provider CCN
 10. NPR Date: 11. Contractor's Vendor Code: 4 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

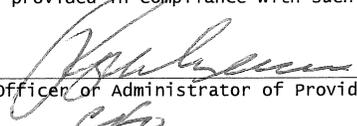
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR 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 MAJOR HOSPITAL (150097) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 4/28/2016 Time: 3:25 pm
 KGSrAsCFZBSmVnEnqpr2ajJRnr0
 Yx31o0wtDwDCQn1KROIUAQBcn61mUH
 bv1j1HG1a206iHEW
 PI: Date: 4/28/2016 Time: 3:25 pm
 frI5e1tnXwgZfyftiRocub1cc4dMO
 udK0s0dmxmg2dFZVnn83gYkrdj81j1
 0Drr0cHEqi0pDMQk

(Signed) 
 Officer or Administrator of Provider(s)
 Title
 5-2-2016
 Date

	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	62,006	38,770	0	-171,340	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0		0	11.00
200.00 Total	0	62,006	38,770	0	-171,340	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: 150097		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 4/28/2016 3:20 pm						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 150 WEST WASHINGTON ST		PO Box:						1.00			
2.00	City: SHELBYVILLE		State: IN		Zip Code: 46176-		County: IN		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		MAJOR HOSPITAL		150097	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA		MAJOR HOSPITAL		157418	99915		03/22/1995	N	P	N	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)					01/01/2015		12/31/2015		20.00		
21.00	Type of Control (see instructions)							2		21.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y		N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N		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.					440	1,086	0	0	570	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.					0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 4/28/2016 3:20 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y		Y		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	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
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

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		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		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<u>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.</u>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	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		
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		XIX			
		1.00		2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N			96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		97.00
Rural Providers							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N					105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N					106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 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		Speech		Respiratory	
		1.00		3.00		4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.					N	
						1.00	
						2.00	
						3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	215,659		0		0	
						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					
119.00	DO NOT USE THIS LINE						
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N			120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y					121.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N					
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.						
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.						
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.						
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.						
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.						
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.						
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.						
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.						
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.						

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150097		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 4/28/2016 3:20 pm	
		1.00		2.00			
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	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	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						1.00	
Multi campus							
165.00	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	
		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	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
168.01	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)					9.99	
		Beginni ng		Endi ng			
		1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2015		12/31/2015		170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 4/28/2016 3:20 pm
			1.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N 171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 4/28/2016 3:20 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		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	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/05/2016	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-2
Part II
Date/Time Prepared:
4/28/2016 3:20 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been 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.			Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMITH@BLUEANDCO.COM	43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	04/05/2016		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
4/28/2016 3:20 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	52	18,980	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)		52	18,980	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	9	3,285	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						13.00
14.00 Total (see instructions)		61	22,265	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	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	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		61				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: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
4/28/2016 3:20 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)	4,445	438	9,336			1.00
2.00 HMO and other (see instructions)	1,172	1,626				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)	4,445	438	9,336			7.00
8.00 INTENSIVE CARE UNIT	560	0	1,086			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)	5,005	438	10,422	0.00	603.12	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	8,552	269	10,601	0.00	12.46	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	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	615.58	27.00
28.00 Observation Bed Days		268	1,044			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	32	60			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: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
4/28/2016 3:20 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	1,217	108	2,722	1.00
2.00 HMO and other (see instructions)			268	450		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	1,217	108	2,722	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					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	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					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: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part II Date/Time Prepared: 4/28/2016 3:20 pm		
	Worksheet A Line Number	Amount Reported	Reclassifi- cation 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	39,635,045	0	39,635,045	1,265,622.00	31.32	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		419,527	0	419,527	2,316.00	181.14	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		3,306,300	0	3,306,300	9,433.00	350.50	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,461,646	212,576	3,674,222	81,970.00	44.82	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		173,158	0	173,158	4,673.00	37.05	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		889,609	0	889,609	5,394.00	164.93	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		8,526,826	0	8,526,826			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		735,456	0	735,456			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		17,851	0	17,851			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		474,001	0	474,001			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	504,997	0	504,997	10,892.00	46.36	26.00
27.00	Administrative & General	5.00	7,258,436	-212,576	7,045,860	234,700.00	30.02	27.00
28.00	Administrative & General under contract (see inst.)		663,363	0	663,363	3,988.00	166.34	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	802,128	0	802,128	31,731.00	25.28	30.00
31.00	Laundry & Linen Service	8.00	31,318	0	31,318	2,434.00	12.87	31.00
32.00	Housekeeping	9.00	767,797	0	767,797	55,700.00	13.78	32.00
33.00	Housekeeping under contract (see instructions)		170,185	0	170,185	1,909.00	89.15	33.00
34.00	Dietary	10.00	552,810	-383,111	169,699	11,900.00	14.26	34.00
35.00	Dietary under contract (see instructions)		214,392	0	214,392	6,260.00	34.25	35.00
36.00	Cafeteria	11.00	0	383,111	383,111	27,727.00	13.82	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,098,634	0	1,098,634	30,051.00	36.56	38.00
39.00	Central Services and Supply	14.00	176,415	-176,415	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	854,099	0	854,099	22,952.00	37.21	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-3
Part II
Date/Time Prepared:
4/28/2016 3:20 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 807,955	0	807,955	35,493.00	22.76	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: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-3
Part III
Date/Time Prepared:
4/28/2016 3:20 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)	37,376,685	0	37,376,685	1,268,346.00	29.47	1.00
2.00	Excluded area salaries (see instructions)	3,461,646	212,576	3,674,222	81,970.00	44.82	2.00
3.00	Subtotal salaries (line 1 minus line 2)	33,915,039	-212,576	33,702,463	1,186,376.00	28.41	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,062,767	0	1,062,767	10,067.00	105.57	4.00
5.00	Subtotal wage-related costs (see inst.)	8,544,677	0	8,544,677	0.00	25.35	5.00
6.00	Total (sum of lines 3 thru 5)	43,522,483	-212,576	43,309,907	1,196,443.00	36.20	6.00
7.00	Total overhead cost (see instructions)	13,902,529	-388,991	13,513,538	475,737.00	28.41	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-3
Part IV
Date/Time Prepared:
4/28/2016 3:20 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,906,150	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	4,665,613	8.00
9.00	Prescription Drug Plan	29,603	9.00
10.00	Dental, Hearing and Vision Plan	40,435	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	57,235	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	133,014	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	186,775	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,639,617	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	57,135	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	38,557	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,754,134	24.00
Part B - Other than Core Related Cost			
25.00	OTHER	31,948	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-3
Part V
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 150097 Component CCN: 157418		Period: From 01/01/2015 To 12/31/2015		Worksheet S-4 Date/Time Prepared: 4/28/2016 3:20 pm		
				Home Health Agency I		PPS		
							1.00	
0.00	County							0.00
		Title V	Title XVIII	Title XIX	Other	Total		
		1.00	2.00	3.00	4.00	5.00		
HOME HEALTH AGENCY STATISTICAL DATA								
1.00	Home Health Aide Hours	0	0	0	0	0	1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	324.00	0.00	0.00	0.00	2.00	
		Number of Employees (Full Time Equivalent)						
		Enter the number of hours in your normal work week			Staff	Contract	Total	
		0	1.00	2.00	3.00			
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES								
3.00	Administrator and Assistant Administrator(s)	0.00					3.00	
4.00	Director(s) and Assistant Director(s)	0.00					4.00	
5.00	Other Administrative Personnel	0.00					5.00	
6.00	Direct Nursing Service	0.00					6.00	
7.00	Nursing Supervisor	0.00					7.00	
8.00	Physical Therapy Service	0.00					8.00	
9.00	Physical Therapy Supervisor	0.00					9.00	
10.00	Occupational Therapy Service	0.00					10.00	
11.00	Occupational Therapy Supervisor	0.00					11.00	
12.00	Speech Pathology Service	0.00					12.00	
13.00	Speech Pathology Supervisor	0.00					13.00	
14.00	Medical Social Service	0.00					14.00	
15.00	Medical Social Service Supervisor	0.00					15.00	
16.00	Home Health Aide	0.00					16.00	
17.00	Home Health Aide Supervisor	0.00					17.00	
18.00	Other (specify)	0.00					18.00	
HOME HEALTH AGENCY CBSA CODES								
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				2		19.00	
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	26900					20.00	
20.01		50032					20.01	
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)		
		Without Outliers	With Outliers	3.00	4.00	5.00		
		1.00	2.00	3.00	4.00	5.00		
PPS ACTIVITY DATA								
21.00	Skilled Nursing Visits	3,578	644	56	17	4,295	21.00	
22.00	Skilled Nursing Visit Charges	794,316	142,968	12,432	3,774	953,490	22.00	
23.00	Physical Therapy Visits	2,105	185	13	16	2,319	23.00	
24.00	Physical Therapy Visit Charges	444,155	39,035	2,743	3,376	489,309	24.00	
25.00	Occupational Therapy Visits	462	84	1	0	547	25.00	
26.00	Occupational Therapy Visit Charges	103,026	18,732	223	0	121,981	26.00	
27.00	Speech Pathology Visits	13	4	0	0	17	27.00	
28.00	Speech Pathology Visit Charges	2,951	908	0	0	3,859	28.00	
29.00	Medical Social Service Visits	39	9	1	0	49	29.00	
30.00	Medical Social Service Visit Charges	12,012	2,772	308	0	15,092	30.00	
31.00	Home Health Aide Visits	929	391	5	0	1,325	31.00	
32.00	Home Health Aide Visit Charges	104,048	43,792	560	0	148,400	32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	7,126	1,317	76	33	8,552	33.00	
34.00	Other Charges	0	0	0	0	0	34.00	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,460,508	248,207	16,266	7,150	1,732,131	35.00	
36.00	Total Number of Episodes (standard/non outlier)	362		26	3	391	36.00	
37.00	Total Number of Outlier Episodes		26		0	26	37.00	
38.00	Total Non-Routine Medical Supply Charges	226	0	0	0	226	38.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 4/28/2016 3:20 pm
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				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)		0.267850		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		3,949,019		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		4,432,566		5.00
6.00	Medicaid charges		22,117,192		6.00
7.00	Medicaid cost (line 1 times line 6)		5,924,090		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	5,409,857	0	5,409,857	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,449,030	0	1,449,030	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,449,030	0	1,449,030	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		7,424,942		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		207,444		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		7,217,498		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,933,207		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,382,237		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,382,237		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet A
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		2,848,702	2,848,702	0	2,848,702	1.00
3.00	00300		0	0	0	0	3.00
4.00	00400		7,757,937	7,757,937	0	7,757,937	4.00
5.01	01160	504,997	0	504,997	15,000	519,997	5.01
5.02	00550	1,162,508	2,580,023	3,742,531	0	3,742,531	5.02
5.03	00590	226,025	111,875	337,900	0	337,900	5.03
5.04	00570	974,924	107,236	1,082,160	-15,000	1,067,160	5.04
5.05	00580	541,536	1,068,156	1,609,692	0	1,609,692	5.05
5.06	00592	4,353,443	4,291,308	8,644,751	-366,038	8,278,713	5.06
7.00	00700	802,128	1,338,903	2,141,031	0	2,141,031	7.00
8.00	00800	31,318	185,210	216,528	0	216,528	8.00
9.00	00900	767,797	435,001	1,202,798	0	1,202,798	9.00
10.00	01000	552,810	912,208	1,465,018	-1,015,294	449,724	10.00
11.00	01100	0	0	0	1,015,294	1,015,294	11.00
13.00	01300	1,098,634	242,920	1,341,554	0	1,341,554	13.00
14.00	01400	176,415	258,750	435,165	-435,165	0	14.00
15.00	01500	854,099	5,409,407	6,263,506	0	6,263,506	15.00
16.00	01600	807,955	324,431	1,132,386	0	1,132,386	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	5,452,174	1,209,449	6,661,623	25,308	6,686,931	30.00
31.00	03100	1,075,094	350,049	1,425,143	0	1,425,143	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,900,193	1,464,913	4,365,106	176,429	4,541,535	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	2,483,890	359,801	2,843,691	0	2,843,691	53.00
54.00	05400	2,096,882	2,843,916	4,940,798	0	4,940,798	54.00
56.00	05600	0	0	0	0	0	56.00
56.01	05601	1,120,687	864,683	1,985,370	0	1,985,370	56.01
57.00	05700	316,411	507,038	823,449	0	823,449	57.00
58.00	05800	310,063	394,094	704,157	0	704,157	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	1,832,889	2,765,897	4,598,786	0	4,598,786	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	802,768	194,636	997,404	0	997,404	65.00
65.01	06501	402,031	199,777	601,808	0	601,808	65.01
66.00	06600	1,441,915	598,281	2,040,196	0	2,040,196	66.00
69.00	06900	478,678	174,714	653,392	0	653,392	69.00
71.00	07100	91,693	3,030,357	3,122,050	-1,487,423	1,634,627	71.00
72.00	07200	0	0	0	1,487,423	1,487,423	72.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	230,291	113,894	344,185	0	344,185	90.00
91.00	09100	2,283,151	1,617,110	3,900,261	233,428	4,133,689	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
97.00	09700	0	0	0	0	0	97.00
100.00	10000	0	0	0	0	0	100.00
101.00	10100	771,118	540,981	1,312,099	0	1,312,099	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		36,944,517	44,596,660	81,541,177	-366,038	81,175,139	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
190.03	19003	0	0	0	0	0	190.03
190.04	19004	0	0	0	0	0	190.04
190.05	19005	0	0	0	366,038	366,038	190.05
190.06	19006	0	0	0	0	0	190.06
190.07	19007	148,069	506,986	655,055	0	655,055	190.07
190.08	19008	0	0	0	0	0	190.08
190.09	19009	12,412	79,241	91,653	0	91,653	190.09
190.10	19010	0	0	0	0	0	190.10
190.11	19011	0	0	0	0	0	190.11
190.12	19012	0	0	0	0	0	190.12
190.13	19013	0	0	0	0	0	190.13

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet A
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
190.14	19014	SPORTSWORKS	0	0	0	0	0	190.14
190.15	19015	SHELBY PEDS	0	0	0	0	0	190.15
190.16	19016	RENOVO	3,894	43,959	47,853	0	47,853	190.16
190.17	19017	I MA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	1,296,750	1,296,750	0	1,296,750	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	1,870,567	216,136	2,086,703	0	2,086,703	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	655,586	182,971	838,557	0	838,557	194.00
200.00		TOTAL (SUM OF LINES 118-199)	39,635,045	46,922,703	86,557,748	0	86,557,748	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet A
Date/Time Prepared:
4/28/2016 3:20 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	-293,056	2,555,646	1.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,407	7,754,530	4.00
5.01	01160	COMMUNICATIONS	-3,037	11,963	5.01
5.02	00550	DATA PROCESSING	-290,120	3,452,411	5.02
5.03	00590	PURCHASING, RECEIVING, AND STORES	0	337,900	5.03
5.04	00570	ADMINISTRATIVE	-6,731	1,060,429	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	-56,796	1,552,896	5.05
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL	-1,450,096	6,828,617	5.06
7.00	00700	OPERATION OF PLANT	0	2,141,031	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	216,528	8.00
9.00	00900	HOUSEKEEPING	-530	1,202,268	9.00
10.00	01000	DIETARY	-224,508	225,216	10.00
11.00	01100	CAFETERIA	-601,711	413,583	11.00
13.00	01300	NURSING ADMINISTRATION	-129,143	1,212,411	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-146,424	6,117,082	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-29,050	1,103,336	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-275,773	6,411,158	30.00
31.00	03100	INTENSIVE CARE UNIT	-29,371	1,395,772	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-569,489	3,972,046	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-1,970,539	873,152	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,037,004	3,903,794	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
56.01	05601	ONCOLOGY	-201,019	1,784,351	56.01
57.00	05700	CT SCAN	-106,126	717,323	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-50,012	654,145	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-253,112	4,345,674	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-24,661	972,743	65.00
65.01	06501	SLEEP LAB	-18,627	583,181	65.01
66.00	06600	PHYSICAL THERAPY	-118,268	1,921,928	66.00
69.00	06900	ELECTROCARDIOLOGY	-84,374	569,018	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-125,752	1,508,875	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,487,423	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-303,169	41,016	90.00
91.00	09100	EMERGENCY	-881,170	3,252,519	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	-478	1,311,621	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-9,283,553	71,891,586	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	190.01
190.02	19002	SICK CHILD CARE	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	190.03
190.04	19004	ST. VINCENT'S STRESS	0	0	190.04
190.05	19005	MARKETING	0	366,038	190.05
190.06	19006	MH LIGHTBOUND	0	0	190.06
190.07	19007	I-74 CAMPUS	0	655,055	190.07
190.08	19008	SOUTHEAST OB	0	0	190.08
190.09	19009	INTELLI PLEX DEVELOPMENT	0	91,653	190.09
190.10	19010	MS&M	0	0	190.10
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	190.11
190.12	19012	BARTLEY ORTHOPEDICS	0	0	190.12
190.13	19013	SSA	0	0	190.13
190.14	19014	SPORTSWORKS	0	0	190.14
190.15	19015	SHELBY PEDS	0	0	190.15

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet A
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
190.16	19016	RENOVO	0	47,853	190.16
190.17	19017	I MA	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	190.18
190.19	19019	MHCD	-19,783	1,276,967	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	HOSPITALIST	-9,229	2,077,474	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	-4,370	834,187	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-9,316,935	77,240,813	200.00

RECLASSIFICATIONS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet A-6

Date/Time Prepared:
4/28/2016 3:20 pm

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	383,111	632,183	1.00
	O		383,111	632,183	
B - COMMUNICATIONS					
1.00	COMMUNICATIONS	5.01	15,000	0	1.00
	O		15,000	0	
C - CS&R OTHER					
1.00	ADULTS & PEDIATRICS	30.00	10,260	15,048	1.00
2.00	OPERATING ROOM	50.00	71,524	104,905	2.00
3.00	EMERGENCY	91.00	94,631	138,797	3.00
	O		176,415	258,750	
D - MARKETING					
1.00	MARKETING	190.05	212,576	153,462	1.00
	O		212,576	153,462	
E - IMPLANTABLE DEVICES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	41,392	1,446,031	1.00
	O		41,392	1,446,031	
500.00	Grand Total: Increases		828,494	2,490,426	500.00

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet A-6
Date/Time Prepared:
4/28/2016 3:20 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA						
1.00	DIETARY	10.00	383,111	632,183	0	1.00
	O		383,111	632,183		
B - COMMUNICATIONS						
1.00	ADMINISTRATIVE	5.04	15,000	0	0	1.00
	O		15,000	0		
C - CS&R OTHER						
1.00	CENTRAL SERVICES & SUPPLY	14.00	176,415	258,750	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	O		176,415	258,750		
D - MARKETING						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	212,576	153,462	0	1.00
	O		212,576	153,462		
E - IMPLANTABLE DEVICES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	41,392	1,446,031	0	1.00
	O		41,392	1,446,031		
500.00	Grand Total: Decreases		828,494	2,490,426		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet A-7
Part I
Date/Time Prepared:
4/28/2016 3:20 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	1,737,322	241,034	0	241,034	0 1.00
2.00	Land Improvements	5,939,611	110,177	0	110,177	17,566 2.00
3.00	Buildings and Fixtures	35,824,543	53,709,611	0	53,709,611	2,888,022 3.00
4.00	Building Improvements	3,436,943	315,667	0	315,667	14,658 4.00
5.00	Fixed Equipment	1,731,959	73,946	0	73,946	937,549 5.00
6.00	Movable Equipment	33,250,141	2,159,568	0	2,159,568	4,283,727 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	81,920,519	56,610,003	0	56,610,003	8,141,522 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	81,920,519	56,610,003	0	56,610,003	8,141,522 10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,978,356	0			1.00
2.00	Land Improvements	6,032,222	0			2.00
3.00	Buildings and Fixtures	86,646,132	0			3.00
4.00	Building Improvements	3,737,952	0			4.00
5.00	Fixed Equipment	868,356	0			5.00
6.00	Movable Equipment	31,125,982	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	130,389,000	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	130,389,000	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet A-7
Part II
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	2,550,359	0	287,837	0	0	1.00
3.00	Total (sum of lines 1-2)	2,550,359	0	287,837	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	10,506	2,848,702				1.00
3.00	Total (sum of lines 1-2)	10,506	2,848,702				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet A-7
Part III
Date/Time Prepared:
4/28/2016 3:20 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	130,389,000	0	130,389,000	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	130,389,000	0	130,389,000	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	2,545,140	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	2,545,140	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	10,506	2,555,646	1.00
3.00	Total (sum of lines 1-2)	0	0	0	10,506	2,555,646	3.00

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	3.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-287,837	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00		2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-3,037	COMMUNICATIONS	5.01	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-3,886,248			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-321,515	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		0		0.00	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		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 FOOD AND NUTRITION	B	-11,130	DIETARY	10.00	0	33.00
34.00 DIABETIC ED	B	-124,516	NURSING ADMINISTRATION	13.00	0	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	3.00	
35.00 CAFETERIA - EMP	A	-280,196	CAFETERIA		11.00	0 35.00
36.00 MH OTHER REVENUES RENTAL INCOME	B	-2,451	CAP REL COSTS-BLDG & FIXT		1.00	9 36.00
37.00 MH INFO. SYSTEMS CONTRACT LABOR	A	-290,120	DATA PROCESSING		5.02	0 37.00
38.00 MH REGISTRATION CONTRACT LABOR	A	-6,731	ADMINING		5.04	0 38.00
39.00 MH PT FINANCE SVCS CONTRACT LABOR	A	-56,796	CASHIERING/ACCOUNTS RECEIVABLE		5.05	0 39.00
40.00 MH ACCOUNTING CONTRACT LABOR	A	-144,406	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 40.00
41.00 MH ADMINISTRATION CONTRACT LABOR	A	-382,287	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 41.00
42.00 MH EDUCATION CLASS REVENUE	B	-12,512	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 42.00
43.00 MH MDSOLUTIONS-ADM RENTAL INCOME	B	-31,420	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 43.00
44.00 MH ACCOUNTING VENDOR REBATES	B	-26,444	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 44.00
45.00 MH OTHER REVENUES PURCHASE DISCOUNTS	B	-4,046	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 45.00
45.01 MH OTHER REVENUES REAPPOINTMENT FEES	B	-3,350	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 45.01
45.02 MH OTHER REVENUES MISCELLANEOUS INCOME	B	-6,775	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 45.02
45.03 MH CL NUTR/DIABED CLASS REVENUE	B	-1,319	NURSING ADMINISTRATION		13.00	0 45.03
45.04 MH CL NUTR/DIABED OTHER CAFETERIA R	B	-2,859	NURSING ADMINISTRATION		13.00	0 45.04
45.05 MH PHARMACY VENDOR REBATES	B	-5,096	PHARMACY		15.00	0 45.05
45.06 MH OTHER REVENUES XEROX AND COPYING	B	-29,050	MEDICAL RECORDS & LIBRARY		16.00	0 45.06
45.07 MH COMM. OUTREACH CONTRACT LABOR	A	-34,410	ADULTS & PEDIATRICS		30.00	0 45.07
45.08 MH OTHER REVENUES BABY PHOTO INCOME	B	-405	ADULTS & PEDIATRICS		30.00	0 45.08
45.09 MH REHAB SVCS-SWK CONTRACT LABOR	A	-91,920	PHYSICAL THERAPY		66.00	0 45.09
45.10 MH CAR MGT & REHAB CONTRACT LABOR	A	-4,342	ELECTROCARDIOLOGY		69.00	0 45.10
45.11 MH CENTRAL SUPPLY VENDOR REBATES	B	-51,038	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0 45.11
45.12 MH MED. SPEC. CNTR RENTAL INCOME	B	-183,463	CLINIC		90.00	0 45.12
45.13 MEALS ON WHEELS	A	-213,378	DIETARY		10.00	0 45.13
45.14 DEPR - OLD B&F	A	-2,768	CAP REL COSTS-BLDG & FIXT		1.00	9 45.14
45.15 IHHA/AHA DUES	A	-5,216	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 45.15
45.16 PROMOTIONAL GIFTS	A	-391	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 45.16
45.17 PROMOTIONAL GIFTS	A	-2,496	OTHER ADMINISTRATIVE AND GENERAL		5.06	9 45.17
45.18 PROMOTIONAL GIFTS	A	-530	HOUSEKEEPING		9.00	0 45.18
45.19 PROMOTIONAL GIFTS	A	-1,072	ADULTS & PEDIATRICS		30.00	0 45.19
45.20 PROMOTIONAL GIFTS	A	-615	RADIOLOGY-DIAGNOSTIC		54.00	0 45.20
45.21 PROMOTIONAL GIFTS	A	-2,776	ONCOLOGY		56.01	0 45.21
45.22 PROMOTIONAL GIFTS	A	-644	RESPIRATORY THERAPY		65.00	0 45.22
45.23 PROMOTIONAL GIFTS	A	-663	SLEEP LAB		65.01	0 45.23
45.24 PROMOTIONAL GIFTS	A	-3,127	PHYSICAL THERAPY		66.00	0 45.24
45.25 PROMOTIONAL GIFTS	A	-1,249	ELECTROCARDIOLOGY		69.00	0 45.25
45.26 ADVERTISING EXPENSE	A	-1,755	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 45.26
45.27 ADVERTISING EXPENSE	A	-5,079	RADIOLOGY-DIAGNOSTIC		54.00	0 45.27
45.28 ADVERTISING EXPENSE	A	-834	ONCOLOGY		56.01	0 45.28
45.29 ADVERTISING EXPENSE	A	-255	PHYSICAL THERAPY		66.00	0 45.29
45.30 COMMUNITY OUTREACH	A	-695,850	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 45.30
45.31 HAF EXPENSE	A	-131,000	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 45.31
45.32 HAF EXPENSE	A	-449	NURSING ADMINISTRATION		13.00	0 45.32
45.33 HAF EXPENSE	A	-141,328	PHARMACY		15.00	0 45.33
45.34 HAF EXPENSE	A	-239,886	ADULTS & PEDIATRICS		30.00	0 45.34

Provider CCN: 150097
 Period: From 01/01/2015 To 12/31/2015
 Worksheet A-8
 Date/Time Prepared: 4/28/2016 3:20 pm

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	
45.35 HAF EXPENSE	A	-29,371	INTENSIVE CARE UNIT	31.00	0 45.35
45.36 HAF EXPENSE	A	-209,489	OPERATING ROOM	50.00	0 45.36
45.37 HAF EXPENSE	A	-47,346	ANESTHESIOLOGY	53.00	0 45.37
45.38 HAF EXPENSE	A	-154,022	RADIOLOGY-DIAGNOSTIC	54.00	0 45.38
45.39 HAF EXPENSE	A	-41,260	ONCOLOGY	56.01	0 45.39
45.40 HAF EXPENSE	A	-103,642	CT SCAN	57.00	0 45.40
45.41 HAF EXPENSE	A	-50,012	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0 45.41
45.42 HAF EXPENSE	A	-253,112	LABORATORY	60.00	0 45.42
45.43 HAF EXPENSE	A	-24,017	RESPIRATORY THERAPY	65.00	0 45.43
45.44 HAF EXPENSE	A	-17,964	SLEEP LAB	65.01	0 45.44
45.45 HAF EXPENSE	A	-21,518	PHYSICAL THERAPY	66.00	0 45.45
45.46 HAF EXPENSE	A	-21,343	ELECTROCARDIOLOGY	69.00	0 45.46
45.47 HAF EXPENSE	A	-74,714	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0 45.47
45.48 HAF EXPENSE	A	-3,487	CLINIC	90.00	0 45.48
45.49 HAF EXPENSE	A	-494,698	EMERGENCY	91.00	0 45.49
45.50 HAF EXPENSE	A	-478	HOME HEALTH AGENCY	101.00	0 45.50
45.51 HAF EXPENSE	A	-19,783	MHCD	190.19	0 45.51
45.52 HAF EXPENSE	A	-9,229	HOSPITALIST	192.01	0 45.52
45.53 HAF EXPENSE	A	-4,370	OTHER NONREIMBURSABLE COST CENTERS	194.00	0 45.53
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,316,935			50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet A-8-2

Date/Time Prepared:
4/28/2016 3:20 pm

1.00	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	28,833	0	28,833	179,000	300	1.00
2.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	28,356	0	28,356	179,000	300	2.00
3.00	50.00	OPERATING ROOM	360,000	360,000	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	2,189,756	1,770,229	419,527	239,400	2,316	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	877,288	877,288	0	0	0	5.00
6.00	56.01	ONCOLOGY	173,404	151,320	22,084	271,900	132	6.00
7.00	57.00	CT SCAN	2,484	2,484	0	0	0	7.00
8.00	60.00	LABORATORY	55,099	0	55,099	260,300	726	8.00
9.00	66.00	PHYSICAL THERAPY	8,333	0	8,333	179,000	80	9.00
10.00	69.00	ELECTROCARDIOLOGY	57,440	57,440	0	0	0	10.00
11.00	90.00	CLINIC	162,776	75,043	87,733	179,000	541	11.00
12.00	91.00	EMERGENCY	671,667	12,496	659,171	179,000	3,314	12.00
200.00			4,615,436	3,306,300	1,309,136		7,709	200.00

1.00	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	25,817	1,291	0	0	0	1.00
2.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	25,817	1,291	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	266,563	13,328	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	56.01	ONCOLOGY	17,255	863	0	0	0	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	90,855	4,543	0	0	0	8.00
9.00	66.00	PHYSICAL THERAPY	6,885	344	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	90.00	CLINIC	46,557	2,328	0	0	0	11.00
12.00	91.00	EMERGENCY	285,195	14,260	0	0	0	12.00
200.00			764,944	38,248	0	0	0	200.00

1.00	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	25,817	3,016	3,016	1.00
2.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	25,817	2,539	2,539	2.00
3.00	50.00	OPERATING ROOM	0	0	0	360,000	3.00
4.00	53.00	ANESTHESIOLOGY	0	266,563	152,964	1,923,193	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	877,288	5.00
6.00	56.01	ONCOLOGY	0	17,255	4,829	156,149	6.00
7.00	57.00	CT SCAN	0	0	0	2,484	7.00
8.00	60.00	LABORATORY	0	90,855	0	0	8.00
9.00	66.00	PHYSICAL THERAPY	0	6,885	1,448	1,448	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	57,440	10.00
11.00	90.00	CLINIC	0	46,557	41,176	116,219	11.00
12.00	91.00	EMERGENCY	0	285,195	373,976	386,472	12.00
200.00			0	764,944	579,948	3,886,248	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet B
Part I
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATIONS	DATA PROCESSING	
		RELATED COSTS BLDG & FIXT				
	0	1.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,555,646	2,555,646			1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	7,754,530	10,643	7,765,173		4.00
5.01 01160	COMMUNI CATIONS	11,963	5,735	2,977	20,675	5.01
5.02 00550	DATA PROCESSING	3,452,411	13,363	230,694	975	3,697,443 5.02
5.03 00590	PURCHASING, RECEIVING, AND STORES	337,900	14,368	44,854	312	18,674 5.03
5.04 00570	ADMITTING	1,060,429	31,889	190,492	858	186,740 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	1,552,896	0	107,465	0	105,819 5.05
5.06 00592	OTHER ADMINISTRATIVE AND GENERAL	6,828,617	209,173	821,734	1,599	311,233 5.06
7.00 00700	OPERATION OF PLANT	2,141,031	222,989	159,178	0	93,370 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	216,528	10,939	6,215	0	6,225 8.00
9.00 00900	HOUSEKEEPING	1,202,268	5,065	152,365	156	168,066 9.00
10.00 01000	DIETARY	225,216	48,524	33,676	390	118,268 10.00
11.00 01100	CAFETERIA	413,583	76,846	76,026	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,212,411	33,170	218,018	1,443	87,145 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	62,695	0	195	18,674 14.00
15.00 01500	PHARMACY	6,117,082	28,539	169,492	351	68,471 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,103,336	43,419	160,335	624	105,819 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,411,158	478,400	1,084,002	2,969	572,666 30.00
31.00 03100	INTENSIVE CARE UNIT	1,395,772	146,498	213,347	741	118,268 31.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,972,046	191,928	589,722	1,911	261,435 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	873,152	9,283	492,916	0	43,573 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,903,794	183,157	416,116	936	211,638 54.00
56.00 05600	RADIO SOTOPE	0	0	0	0	0 56.00
56.01 05601	ONCOLOGY	1,784,351	327,527	222,395	1,911	112,044 56.01
57.00 05700	CT SCAN	717,323	7,884	62,790	0	18,674 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	654,145	0	61,530	0	24,899 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	4,345,674	39,517	363,728	858	248,986 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00 06500	RESPIRATORY THERAPY	972,743	16,477	159,305	1,248	68,471 65.00
65.01 06501	SLEEP LAB	583,181	0	79,781	156	37,348 65.01
66.00 06600	PHYSICAL THERAPY	1,921,928	12,417	286,141	936	124,493 66.00
69.00 06900	ELECTROCARDIOLOGY	569,018	55,639	94,991	0	62,247 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,508,875	0	9,982	0	18,674 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	1,487,423	0	8,214	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00 09000	CLINIC	41,016	98,487	45,700	663	24,899 90.00
91.00 09100	EMERGENCY	3,252,519	104,478	471,859	819	224,087 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0 97.00
100.00 10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 100.00
101.00 10100	HOME HEALTH AGENCY	1,311,621	0	153,025	0	74,696 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	71,891,586	2,489,049	7,189,065	20,051	3,535,602 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,332	0	0	0 190.00
190.01 19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0 190.01
190.02 19002	SICK CHILD CARE	0	0	0	0	0 190.02
190.03 19003	PRIVATE DUTY	0	0	0	0	0 190.03
190.04 19004	ST. VINCENT'S STRESS	0	0	0	0	0 190.04
190.05 19005	MARKETING	366,038	3,784	42,185	0	12,449 190.05
190.06 19006	MH LIGHTBOUND	0	0	0	0	0 190.06
190.07 19007	I-74 CAMPUS	655,055	0	29,384	0	31,123 190.07
190.08 19008	SOUTHEAST OB	0	0	0	0	0 190.08
190.09 19009	INTELLI PLEX DEVELOPMENT	91,653	0	2,463	0	0 190.09
190.10 19010	MS&M	0	0	0	0	0 190.10
190.11 19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	0 190.11

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet B
Part I
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	DATA PROCESSING	
		BLDG & FIXT					
	0	1.00		4.00	5.01	5.02	
190.12 19012 BARTLEY ORTHOPEDICS	0	0	0	0	0	0	190.12
190.13 19013 SSA	0	0	0	0	0	0	190.13
190.14 19014 SPORTSWORKS	0	0	0	0	0	0	190.14
190.15 19015 SHELBY PEDS	0	0	0	0	0	0	190.15
190.16 19016 RENOVO	47,853	0	0	773	0	0	190.16
190.17 19017 IMA	0	0	0	0	0	0	190.17
190.18 19018 MD SOLUTIONS	0	0	0	0	0	0	190.18
190.19 19019 MHCD	1,276,967	5,203	0	0	0	0	190.19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	192.00
192.01 19201 HOSPITALIST	2,077,474	0	0	371,205	39	56,022	192.01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	834,187	50,278	0	130,098	585	62,247	194.00
200.00							200.00
201.00			0	0	0	0	201.00
202.00							202.00
202.00	TOTAL (sum lines 118-201)	77,240,813	2,555,646	7,765,173	20,675	3,697,443	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet B
Part I
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description		PURCHASING, RECEIVING, AND STORES	ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
		5.03	5.04	5.05	5A.05	5.06	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00590	416,108					5.03
5.04	00570	4,201	1,474,609				5.04
5.05	00580	3,072	0	1,769,252			5.05
5.06	00592	7,055	0	0	8,179,411	8,179,411	5.06
7.00	00700	526	0	0	2,617,094	309,961	7.00
8.00	00800	14	0	0	239,921	28,416	8.00
9.00	00900	6,492	0	0	1,534,412	181,731	9.00
10.00	01000	3,696	0	0	429,770	50,901	10.00
11.00	01100	0	0	0	566,455	67,089	11.00
13.00	01300	7,653	0	0	1,559,840	184,743	13.00
14.00	01400	13,334	0	0	94,898	11,239	14.00
15.00	01500	4,269	0	0	6,388,204	756,600	15.00
16.00	01600	1,829	0	0	1,415,362	167,631	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	51,684	85,205	102,228	8,788,312	1,040,845	30.00
31.00	03100	23,822	21,558	25,865	1,945,871	230,463	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	106,738	193,961	232,713	5,550,454	657,379	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	19,899	6,924	8,307	1,454,054	172,214	53.00
54.00	05400	9,880	126,398	151,650	5,003,569	592,608	54.00
56.00	05600	0	0	0	0	0	56.00
56.01	05601	12,811	62,929	75,501	2,599,469	307,873	56.01
57.00	05700	4,649	116,165	139,373	1,066,858	126,355	57.00
58.00	05800	2,237	56,478	67,762	867,051	102,691	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	41,406	203,804	244,522	5,488,495	650,041	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	6,093	21,848	26,213	1,272,398	150,699	65.00
65.01	06501	3,705	23,199	27,834	755,204	89,444	65.01
66.00	06600	6,786	37,360	44,825	2,434,886	288,381	66.00
69.00	06900	8,976	31,221	37,459	859,551	101,803	69.00
71.00	07100	0	53,832	64,586	1,655,949	196,126	71.00
72.00	07200	0	44,298	53,148	1,593,083	188,680	72.00
73.00	07300	0	134,007	160,780	294,787	34,914	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	1,367	1,260	1,512	214,904	25,453	90.00
91.00	09100	40,484	241,722	290,049	4,626,017	547,892	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
97.00	09700	0	0	0	0	0	97.00
100.00	10000	0	0	0	0	0	100.00
101.00	10100	8,322	12,440	14,925	1,575,029	186,542	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		401,000	1,474,609	1,769,252	71,071,308	7,448,714	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	7,332	868	190.00
190.01	19001	0	0	0	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
190.03	19003	0	0	0	0	0	190.03
190.04	19004	0	0	0	0	0	190.04
190.05	19005	0	0	0	424,456	50,271	190.05
190.06	19006	0	0	0	0	0	190.06
190.07	19007	57	0	0	715,619	84,756	190.07
190.08	19008	0	0	0	0	0	190.08
190.09	19009	0	0	0	94,116	11,147	190.09
190.10	19010	0	0	0	0	0	190.10
190.11	19011	0	0	0	0	0	190.11
190.12	19012	0	0	0	0	0	190.12
190.13	19013	0	0	0	0	0	190.13
190.14	19014	0	0	0	0	0	190.14
190.15	19015	0	0	0	0	0	190.15

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet B
Part I
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description			PURCHASING, RECEIVING, AND STORES	ADMINISTRATIVE	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			5.03	5.04	5.05	5A.05	5.06	
190.16	19016	RENOVO	0	0	0	48,626	5,759	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	1,282,170	151,856	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	8	0	0	2,504,748	296,655	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	15,043	0	0	1,092,438	129,385	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	416,108	1,474,609	1,769,252	77,240,813	8,179,411	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00590	PURCHASING, RECEIVING, AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT	2,927,055				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,638	283,975			8.00
9.00	00900	HOUSEKEEPING	7,241	0	1,723,384		9.00
10.00	01000	DIETARY	69,369	0	41,165	591,205	10.00
11.00	01100	CAFETERIA	109,858	0	65,191	0	11.00
13.00	01300	NURSING ADMINISTRATION	47,420	0	28,140	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	89,628	0	53,186	0	14.00
15.00	01500	PHARMACY	40,799	0	24,211	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	62,072	0	36,834	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	683,912	109,635	405,844	529,600	30.00
31.00	03100	INTENSIVE CARE UNIT	209,432	17,038	124,280	61,605	31.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	274,377	39,579	162,820	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	13,271	0	7,875	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	261,839	34,485	155,379	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
56.01	05601	ONCOLOGY	468,227	0	277,854	0	56.01
57.00	05700	CT SCAN	11,270	0	6,688	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	56,493	7,927	33,524	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	23,555	0	13,978	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	17,751	11,192	10,534	0	66.00
69.00	06900	ELECTROCARDIOLOGY	79,541	2,737	47,201	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	140,795	981	83,550	0	90.00
91.00	09100	EMERGENCY	149,361	60,303	88,633	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,831,849	283,877	1,666,887	591,205	775,108
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,481	0	6,220	0	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	190.01
190.02	19002	SICK CHILD CARE	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	0	190.03
190.04	19004	ST. VINCENT'S STRESS	0	0	0	0	190.04
190.05	19005	MARKETING	5,410	0	3,210	0	190.05
190.06	19006	MH LIGHTBOUND	0	0	0	0	190.06
190.07	19007	I-74 CAMPUS	0	0	0	0	190.07
190.08	19008	SOUTHEAST OB	0	0	0	0	190.08
190.09	19009	INTELLI PLEX DEVELOPMENT	0	0	0	0	190.09
190.10	19010	MS&M	0	0	0	0	190.10
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	190.11
190.12	19012	BARTLEY ORTHOPEDICS	0	0	0	0	190.12
190.13	19013	SSA	0	0	0	0	190.13
190.14	19014	SPORTSWORKS	0	0	0	0	190.14
190.15	19015	SHELBY PEDS	0	0	0	0	190.15
190.16	19016	RENOVO	0	0	0	0	190.16

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
190.17	19017	I MA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	7,438	0	4,414	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	0	0	0	0	17,425	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	71,877	98	42,653	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,927,055	283,975	1,723,384	591,205	808,593	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150097		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part I Date/Time Prepared: 4/28/2016 3:20 pm	
Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00590	PURCHASING, RECEIVING, AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL					5.06
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	1,849,335				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	248,951			14.00
15.00	01500	PHARMACY	0	0	7,232,038		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,716,077	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	597,235	0	0	117,376	12,456,667
31.00	03100	INTENSIVE CARE UNIT	123,622	0	0	23,124	2,773,503
41.00	04100	SUBPROVIDER - I R F	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	267,260	0	0	223,429	7,257,597
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	59,591	0	0	7,975	1,733,330
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	145,598	6,253,363
56.00	05600	RADIOISOTOPE	0	0	0	0	0
56.01	05601	ONCOLOGY	114,544	0	0	72,488	3,875,727
57.00	05700	CT SCAN	0	0	0	133,811	1,356,226
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	65,057	1,044,747
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	234,762	6,550,583
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	73,103	0	0	25,167	1,581,411
65.01	06501	SLEEP LAB	42,103	0	0	26,723	913,474
66.00	06600	PHYSICAL THERAPY	0	0	0	43,036	2,846,794
69.00	06900	ELECTROCARDIOLOGY	57,631	0	0	35,964	1,202,175
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	136,923	0	62,009	2,054,413
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	112,028	0	51,027	1,947,541
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,232,038	154,363	7,716,102
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	27,128	0	0	1,451	502,616
91.00	09100	EMERGENCY	245,001	0	0	278,387	6,071,038
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	80,978	0	0	14,330	1,856,879
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,688,196	248,951	7,232,038	1,716,077	69,994,186
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	24,901
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0
190.02	19002	SICK CHILD CARE	0	0	0	0	0
190.03	19003	PRIVATE DUTY	0	0	0	0	0
190.04	19004	ST. VINCENT'S STRESS	0	0	0	0	0
190.05	19005	MARKETING	0	0	0	0	489,263
190.06	19006	MH LIGHTBOUND	0	0	0	0	0
190.07	19007	I-74 CAMPUS	30,772	0	0	0	840,623
190.08	19008	SOUTHEAST OB	0	0	0	0	0
190.09	19009	INTELLI PLEX DEVELOPMENT	2,169	0	0	0	108,100
190.10	19010	MS&M	0	0	0	0	0
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	0
190.12	19012	BARTLEY ORTHOPEDICS	0	0	0	0	0
190.13	19013	SSA	0	0	0	0	0
190.14	19014	SPORTSWORKS	0	0	0	0	0
190.15	19015	SHELBY PEDS	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150097

Period:
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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
190.16	19016	RENOVO	0	0	0	0	54,385	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	1,445,878	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	56,588	0	0	0	2,875,416	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	71,610	0	0	0	1,408,061	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,849,335	248,951	7,232,038	1,716,077	77,240,813	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150097

Period:
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	01160	COMMUNICATIONS		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00590	PURCHASING, RECEIVING, AND STORES		5.03
5.04	00570	ADMINISTRATIVE		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL		5.06
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
56.00	05600	RADIOISOTOPE	0	56.00
56.01	05601	ONCOLOGY	0	56.01
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	65.00
65.01	06501	SLEEP LAB	0	65.01
66.00	06600	PHYSICAL THERAPY	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	190.01
190.02	19002	SICK CHILD CARE	0	190.02
190.03	19003	PRIVATE DUTY	0	190.03
190.04	19004	ST. VINCENT'S STRESS	0	190.04
190.05	19005	MARKETING	0	190.05
190.06	19006	MHLIGHTBOUND	0	190.06
190.07	19007	I-74 CAMPUS	0	190.07
190.08	19008	SOUTHEAST OB	0	190.08
190.09	19009	INTELLI PLEX DEVELOPMENT	0	190.09
190.10	19010	MS&M	0	190.10
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	190.11
190.12	19012	BARTLEY ORTHOPEDICS	0	190.12
190.13	19013	SSA	0	190.13

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150097

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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
190.14	19014	SPORTSWORKS	0	0	190.14
190.15	19015	SHELBY PEDS	0	0	190.15
190.16	19016	RENOVO	0	54,385	190.16
190.17	19017	IMA	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	190.18
190.19	19019	MHCD	0	1,445,878	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	HOSPITALIST	0	2,875,416	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	1,408,061	194.00
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	77,240,813	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

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Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT					
	0	1.00		2A	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,643	10,643	10,643		4.00
5.01 01160	COMMUNICATIONS	0	5,735	5,735	4	5,739	5.01
5.02 00550	DATA PROCESSING	0	13,363	13,363	316	271	5.02
5.03 00590	PURCHASING, RECEIVING, AND STORES	0	14,368	14,368	61	87	5.03
5.04 00570	ADMITTING	0	31,889	31,889	261	238	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	147	0	5.05
5.06 00592	OTHER ADMINISTRATIVE AND GENERAL	0	209,173	209,173	1,126	444	5.06
7.00 00700	OPERATION OF PLANT	0	222,989	222,989	218	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	10,939	10,939	9	0	8.00
9.00 00900	HOUSEKEEPING	0	5,065	5,065	209	43	9.00
10.00 01000	DIETARY	0	48,524	48,524	46	108	10.00
11.00 01100	CAFETERIA	0	76,846	76,846	104	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	33,170	33,170	299	401	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	62,695	62,695	0	54	14.00
15.00 01500	PHARMACY	0	28,539	28,539	232	97	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	43,419	43,419	220	173	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	478,400	478,400	1,488	823	30.00
31.00 03100	INTENSIVE CARE UNIT	0	146,498	146,498	292	206	31.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	191,928	191,928	808	531	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	9,283	9,283	676	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	183,157	183,157	570	260	54.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01 05601	ONCOLOGY	0	327,527	327,527	305	531	56.01
57.00 05700	CT SCAN	0	7,884	7,884	86	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	84	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	0	39,517	39,517	499	238	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	16,477	16,477	218	347	65.00
65.01 06501	SLEEP LAB	0	0	0	109	43	65.01
66.00 06600	PHYSICAL THERAPY	0	12,417	12,417	392	260	66.00
69.00 06900	ELECTROCARDIOLOGY	0	55,639	55,639	130	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	11	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	98,487	98,487	63	184	90.00
91.00 09100	EMERGENCY	0	104,478	104,478	647	227	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	210	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,489,049	2,489,049	9,854	5,566	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,332	7,332	0	0	190.00
190.01 19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0	190.01
190.02 19002	SICK CHILD CARE	0	0	0	0	0	190.02
190.03 19003	PRIVATE DUTY	0	0	0	0	0	190.03
190.04 19004	ST. VINCENT'S STRESS	0	0	0	0	0	190.04
190.05 19005	MARKETING	0	3,784	3,784	58	0	190.05
190.06 19006	MH LIGHTBOUND	0	0	0	0	0	190.06
190.07 19007	I-74 CAMPUS	0	0	0	40	0	190.07
190.08 19008	SOUTHEAST OB	0	0	0	0	0	190.08
190.09 19009	INTELLI PLEX DEVELOPMENT	0	0	0	3	0	190.09
190.10 19010	MS&M	0	0	0	0	0	190.10
190.11 19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	0	190.11
190.12 19012	BARTLEY ORTHOPEDICS	0	0	0	0	0	190.12

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet B
Part II
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			BLDG & FIXT				
	0	1.00		2A	4.00	5.01	
190.13 19013 SSA	0	0	0	0	0	0	190.13
190.14 19014 SPORTSWORKS	0	0	0	0	0	0	190.14
190.15 19015 SHELBY PEDS	0	0	0	0	0	0	190.15
190.16 19016 RENOVO	0	0	0	0	1	0	190.16
190.17 19017 IMA	0	0	0	0	0	0	190.17
190.18 19018 MD SOLUTIONS	0	0	0	0	0	0	190.18
190.19 19019 MHCD	0	5,203	0	5,203	0	0	190.19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	192.00
192.01 19201 HOSPITALIST	0	0	0	0	509	11	192.01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	50,278	0	50,278	178	162	194.00
200.00 Cross Foot Adjustments				0			200.00
201.00 Negative Cost Centers				0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	2,555,646		2,555,646	10,643	5,739	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150097		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 4/28/2016 3:20 pm		
Cost Center Description		DATA PROCESSING	PURCHASING, RECEIVING, AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL		
		5.02	5.03	5.04	5.05	5.06		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING	13,950					5.02
5.03	00590	PURCHASING, RECEIVING, AND STORES	70	14,586				5.03
5.04	00570	ADMINITTING	705	147	33,240			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	399	108	0	654		5.05
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL	1,174	247	0	0	212,164	5.06
7.00	00700	OPERATION OF PLANT	352	18	0	0	8,040	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23	0	0	0	737	8.00
9.00	00900	HOUSEKEEPING	634	228	0	0	4,714	9.00
10.00	01000	DIETARY	446	130	0	0	1,320	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,740	11.00
13.00	01300	NURSING ADMINISTRATION	329	268	0	0	4,792	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	70	467	0	0	292	14.00
15.00	01500	PHARMACY	258	150	0	0	19,625	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	399	64	0	0	4,348	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,166	1,812	1,928	45	27,002	30.00
31.00	03100	INTENSIVE CARE UNIT	446	835	488	11	5,978	31.00
41.00	04100	SUBPROVIDER - I R F	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	986	3,743	4,389	102	17,051	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	164	697	157	4	4,467	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	798	346	2,860	67	15,371	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	423	449	1,424	33	7,986	56.01
57.00	05700	CT SCAN	70	163	2,629	61	3,277	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	94	78	1,278	30	2,664	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	939	1,451	4,612	107	16,861	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	258	214	494	11	3,909	65.00
65.01	06501	SLEEP LAB	141	130	525	12	2,320	65.01
66.00	06600	PHYSICAL THERAPY	470	238	845	20	7,480	66.00
69.00	06900	ELECTROCARDIOLOGY	235	315	706	16	2,641	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	70	0	1,218	28	5,087	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,002	23	4,894	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,032	71	906	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	94	48	29	1	660	90.00
91.00	09100	EMERGENCY	845	1,419	5,343	5	14,211	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	282	292	281	7	4,838	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,340	14,057	33,240	654	193,211	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	23	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0	190.01
190.02	19002	SICK CHILD CARE	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	0	0	190.03
190.04	19004	ST. VINCENT'S STRESS	0	0	0	0	0	190.04
190.05	19005	MARKETING	47	0	0	0	1,304	190.05
190.06	19006	MH LIGHTBOUND	0	0	0	0	0	190.06
190.07	19007	I-74 CAMPUS	117	2	0	0	2,198	190.07
190.08	19008	SOUTHEAST OB	0	0	0	0	0	190.08
190.09	19009	INTELLEX DEVELOPMENT	0	0	0	0	289	190.09
190.10	19010	MS&M	0	0	0	0	0	190.10
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	0	190.11
190.12	19012	BARTLEY ORTHOPEDICS	0	0	0	0	0	190.12
190.13	19013	SSA	0	0	0	0	0	190.13
190.14	19014	SPORTSWORKS	0	0	0	0	0	190.14
190.15	19015	SHELBY PEDS	0	0	0	0	0	190.15

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 150097		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 4/28/2016 3:20 pm	
Cost Center Description			DATA PROCESSING	PURCHASING, RECEIVING, AND STORES	ADMINISTRATIVE	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
			5.02	5.03	5.04	5.05	5.06	
190.16	19016	RENOVO	0	0	0	0	149	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	3,939	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	211	0	0	0	7,695	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	235	527	0	0	3,356	194.00
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)	13,950	14,586	33,240	654	212,164	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 4/28/2016 3:20 pm				
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	01160	COMMUNICATIONS					5.01	
5.02	00550	DATA PROCESSING					5.02	
5.03	00590	PURCHASING, RECEIVING, AND STORES					5.03	
5.04	00570	ADMITTING					5.04	
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05	
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL					5.06	
7.00	00700	OPERATION OF PLANT	231,617				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	1,237	12,945			8.00	
9.00	00900	HOUSEKEEPING	573	0	11,466		9.00	
10.00	01000	DIETARY	5,489	0	274	56,337	10.00	
11.00	01100	CAFETERIA	8,693	0	434	0	87,817	11.00
13.00	01300	NURSING ADMINISTRATION	3,752	0	187	0	3,170	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,092	0	354	0	0	14.00
15.00	01500	PHARMACY	3,228	0	161	0	2,414	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,912	0	245	0	3,712	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	54,119	4,998	2,701	50,467	19,973	30.00
31.00	03100	INTENSIVE CARE UNIT	16,572	777	827	5,870	4,134	31.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,711	1,804	1,083	0	8,938	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,050	0	52	0	1,993	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,719	1,572	1,034	0	6,504	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	37,051	0	1,849	0	3,831	56.01
57.00	05700	CT SCAN	892	0	44	0	1,221	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	1,080	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,470	361	223	0	8,617	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,864	0	93	0	2,445	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,405	510	70	0	4,454	66.00
69.00	06900	ELECTROCARDIOLOGY	6,294	125	314	0	1,927	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	370	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	11,141	45	556	0	907	90.00
91.00	09100	EMERGENCY	11,819	2,749	590	0	8,194	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	224,083	12,941	11,091	56,337	84,180	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	829	0	41	0	0	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0	190.01
190.02	19002	SICK CHILD CARE	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	0	0	190.03
190.04	19004	ST. VINCENT'S STRESS	0	0	0	0	0	190.04
190.05	19005	MARKETING	428	0	21	0	643	190.05
190.06	19006	MHLIGHTBOUND	0	0	0	0	0	190.06
190.07	19007	I-74 CAMPUS	0	0	0	0	1,029	190.07
190.08	19008	SOUTHEAST OB	0	0	0	0	0	190.08
190.09	19009	INTELLI PLEX DEVELOPMENT	0	0	0	0	73	190.09
190.10	19010	MS&M	0	0	0	0	0	190.10
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	0	190.11
190.12	19012	BARTLEY ORTHOPEDICS	0	0	0	0	0	190.12
190.13	19013	SSA	0	0	0	0	0	190.13
190.14	19014	SPORTSWORKS	0	0	0	0	0	190.14
190.15	19015	SHELBY PEDS	0	0	0	0	0	190.15
190.16	19016	RENOVO	0	0	0	0	0	190.16

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet B
Part II
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
190.17	19017	I MA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	589	0	29	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	0	0	0	0	1,892	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	5,688	4	284	0	0	194.00
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)	231,617	12,945	11,466	56,337	87,817	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150097		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 4/28/2016 3:20 pm	
Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00590	PURCHASING, RECEIVING, AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL					5.06
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	46,368				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	71,024			14.00
15.00	01500	PHARMACY	0	0	54,704		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	57,492	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,974	0	0	3,932	664,828 30.00
31.00	03100	INTENSIVE CARE UNIT	3,100	0	0	775	186,809 31.00
41.00	04100	SUBPROVIDER - I R F	0	0	0	0	0 41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0 42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,701	0	0	7,485	267,260 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	1,494	0	0	267	20,304 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,878	238,136 54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
56.01	05601	ONCOLOGY	2,872	0	0	2,428	386,709 56.01
57.00	05700	CT SCAN	0	0	0	4,483	20,810 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,179	7,487 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	0	0	0	7,865	85,760 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	1,833	0	0	843	29,006 65.00
65.01	06501	SLEEP LAB	1,056	0	0	895	5,231 65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	1,442	30,003 66.00
69.00	06900	ELECTROCARDIOLOGY	1,445	0	0	1,205	70,992 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39,063	0	2,077	47,927 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	31,961	0	1,709	39,896 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	54,704	5,171	63,884 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00	09000	CLINIC	680	0	0	49	112,944 90.00
91.00	09100	EMERGENCY	6,143	0	0	9,329	165,999 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0 97.00
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 100.00
101.00	10100	HOME HEALTH AGENCY	2,030	0	0	480	8,420 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,328	71,024	54,704	57,492	2,452,405 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	8,225 190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0 190.01
190.02	19002	SICK CHILD CARE	0	0	0	0	0 190.02
190.03	19003	PRIVATE DUTY	0	0	0	0	0 190.03
190.04	19004	ST. VINCENT'S STRESS	0	0	0	0	0 190.04
190.05	19005	MARKETING	0	0	0	0	6,285 190.05
190.06	19006	MH LIGHTBOUND	0	0	0	0	0 190.06
190.07	19007	I-74 CAMPUS	772	0	0	0	4,158 190.07
190.08	19008	SOUTHEAST OB	0	0	0	0	0 190.08
190.09	19009	INTELLI PLEX DEVELOPMENT	54	0	0	0	419 190.09
190.10	19010	MS&M	0	0	0	0	0 190.10
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	0 190.11
190.12	19012	BARTLEY ORTHOPEDICS	0	0	0	0	0 190.12
190.13	19013	SSA	0	0	0	0	0 190.13
190.14	19014	SPORTSWORKS	0	0	0	0	0 190.14
190.15	19015	SHELBY PEDS	0	0	0	0	0 190.15

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet B
Part II
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
190.16	19016	RENOVO	0	0	0	0	150	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	9,760	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	1,419	0	0	0	11,737	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	1,795	0	0	0	62,507	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	46,368	71,024	54,704	57,492	2,555,646	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 4/28/2016 3:20 pm
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	01160	COMMUNICATIONS		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00590	PURCHASING, RECEIVING, AND STORES		5.03
5.04	00570	ADMINISTRATIVE		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL		5.06
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
56.00	05600	RADIOISOTOPE	0	56.00
56.01	05601	ONCOLOGY	0	56.01
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	65.00
65.01	06501	SLEEP LAB	0	65.01
66.00	06600	PHYSICAL THERAPY	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	190.01
190.02	19002	SICK CHILD CARE	0	190.02
190.03	19003	PRIVATE DUTY	0	190.03
190.04	19004	ST. VINCENT'S STRESS	0	190.04
190.05	19005	MARKETING	0	190.05
190.06	19006	MH LIGHTBOUND	0	190.06
190.07	19007	I-74 CAMPUS	0	190.07
190.08	19008	SOUTHEAST OB	0	190.08
190.09	19009	INTELLI PLEX DEVELOPMENT	0	190.09
190.10	19010	MS&M	0	190.10
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	190.11
190.12	19012	BARTLEY ORTHOPEDICS	0	190.12
190.13	19013	SSA	0	190.13

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet B
Part II
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
190.14	19014	SPORTSWORKS	0	0	190.14
190.15	19015	SHELBY PEDS	0	0	190.15
190.16	19016	RENOVO	0	150	190.16
190.17	19017	IMA	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	190.18
190.19	19019	MHCD	0	9,760	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	HOSPITALIST	0	11,737	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	62,507	194.00
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	2,555,646	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet B-1

Date/Time Prepared:
4/28/2016 3: 20 pm

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (TELEPHONES)	DATA PROCESSING (HARDWARE)	PURCHASING, RECEIVING, AND STORES (PURCHASING)	
	BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5.01	5.02	5.03	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	129,668					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	540	39,130,048				4.00
5.01 01160 COMMUNICATIONS	291	15,000	530			5.01
5.02 00550 DATA PROCESSING	678	1,162,508	25	594		5.02
5.03 00590 PURCHASING, RECEIVING, AND STORES	729	226,025	8	3	2,060,948	5.03
5.04 00570 ADMITTING	1,618	959,924	22	30	20,806	5.04
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE	0	541,536	0	17	15,217	5.05
5.06 00592 OTHER ADMINISTRATIVE AND GENERAL	10,613	4,140,867	41	50	34,942	5.06
7.00 00700 OPERATION OF PLANT	11,314	802,128	0	15	2,607	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	555	31,318	0	1	70	8.00
9.00 00900 HOUSEKEEPING	257	767,797	4	27	32,156	9.00
10.00 01000 DIETARY	2,462	169,699	10	19	18,307	10.00
11.00 01100 CAFETERIA	3,899	383,111	0	0	0	11.00
13.00 01300 NURSING ADMINISTRATION	1,683	1,098,634	37	14	37,905	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	3,181	0	5	3	66,042	14.00
15.00 01500 PHARMACY	1,448	854,099	9	11	21,145	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	2,203	807,955	16	17	9,057	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	24,273	5,462,434	76	92	255,989	30.00
31.00 03100 INTENSIVE CARE UNIT	7,433	1,075,094	19	19	117,987	31.00
41.00 04100 SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	9,738	2,971,717	49	42	528,662	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	471	2,483,890	0	7	98,557	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	9,293	2,096,882	24	34	48,934	54.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
56.01 05601 ONCOLOGY	16,618	1,120,687	49	18	63,453	56.01
57.00 05700 CT SCAN	400	316,411	0	3	23,027	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	310,063	0	4	11,081	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	2,005	1,832,889	22	40	205,079	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	836	802,768	32	11	30,180	65.00
65.01 06501 SLEEP LAB	0	402,031	4	6	18,349	65.01
66.00 06600 PHYSICAL THERAPY	630	1,441,915	24	20	33,611	66.00
69.00 06900 ELECTROCARDIOLOGY	2,823	478,678	0	10	44,457	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	50,301	0	3	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	41,392	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	4,997	230,291	17	4	6,769	90.00
91.00 09100 EMERGENCY	5,301	2,377,782	21	36	200,512	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00 10000 I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	771,118	0	12	41,216	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 11800 SUBTOTALS (SUM OF LINES 1-117)	126,289	36,226,944	514	568	1,986,117	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	372	0	0	0	0	190.00
190.01 19001 SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0	190.01
190.02 19002 SICK CHILD CARE	0	0	0	0	0	190.02
190.03 19003 PRIVATE DUTY	0	0	0	0	0	190.03
190.04 19004 ST. VINCENT'S STRESS	0	0	0	0	0	190.04
190.05 19005 MARKETING	192	212,576	0	2	0	190.05
190.06 19006 MHLIGHTBOUND	0	0	0	0	0	190.06
190.07 19007 I-74 CAMPUS	0	148,069	0	5	281	190.07
190.08 19008 SOUTHEAST OB	0	0	0	0	0	190.08
190.09 19009 INTELLI PLEX DEVELOPMENT	0	12,412	0	0	0	190.09
190.10 19010 MS&M	0	0	0	0	0	190.10
190.11 19011 OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	0	190.11

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet B-1

Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (TELEPHONES)	DATA PROCESSING (HARDWARE)	PURCHASING, RECEIVING, AND STORES (PURCHASING)	
	BLDG & FIXT (SQUARE FEET)						
	1.00		4.00	5.01	5.02	5.03	
190.12 19012 BARTLEY ORTHOPEDICS	0		0	0	0	0	190.12
190.13 19013 SSA	0		0	0	0	0	190.13
190.14 19014 SPORTSWORKS	0		0	0	0	0	190.14
190.15 19015 SHELBY PEDS	0		0	0	0	0	190.15
190.16 19016 RENOVO	0		3,894	0	0	0	190.16
190.17 19017 IMA	0		0	0	0	0	190.17
190.18 19018 MD SOLUTIONS	0		0	0	0	0	190.18
190.19 19019 MHCD	264		0	0	0	0	190.19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0		0	0	0	0	192.00
192.01 19201 HOSPITALIST	0		1,870,567	1	9	42	192.01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	2,551		655,586	15	10	74,508	194.00
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers							201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2,555,646		7,765,173	20,675	3,697,443	416,108	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	19.709150		0.198445	39.009434	6,224.651515	0.201901	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			10,643	5,739	13,950	14,586	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000272	10.828302	23.484848	0.007077	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet B-1

Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description			ADMITTING (GROSS CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.04	5.05	5A.06	5.06	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00590	PURCHASING, RECEIVING, AND STORES						5.03
5.04	00570	ADMITTING	258,650,519					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	258,650,519				5.05
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL	0	0	-8,179,411	69,061,402		5.06
7.00	00700	OPERATION OF PLANT	0	0	0	2,617,094	103,885	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	239,921	555	8.00
9.00	00900	HOUSEKEEPING	0	0	0	1,534,412	257	9.00
10.00	01000	DIETARY	0	0	0	429,770	2,462	10.00
11.00	01100	CAFETERIA	0	0	0	566,455	3,899	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,559,840	1,683	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	94,898	3,181	14.00
15.00	01500	PHARMACY	0	0	0	6,388,204	1,448	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,415,362	2,203	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,945,666	14,945,666	0	8,788,312	24,273	30.00
31.00	03100	INTENSIVE CARE UNIT	3,781,421	3,781,421	0	1,945,871	7,433	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34,022,362	34,022,362	0	5,550,454	9,738	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,214,478	1,214,478	0	1,454,054	471	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,171,122	22,171,122	0	5,003,569	9,293	54.00
56.00	05600	RADIOLOGY-SOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	11,038,165	11,038,165	0	2,599,469	16,618	56.01
57.00	05700	CT SCAN	20,376,214	20,376,214	0	1,066,858	400	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,906,723	9,906,723	0	867,051	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	35,748,815	35,748,815	0	5,488,495	2,005	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	3,832,347	3,832,347	0	1,272,398	836	65.00
65.01	06501	SLEEP LAB	4,069,354	4,069,354	0	755,204	0	65.01
66.00	06600	PHYSICAL THERAPY	6,553,297	6,553,297	0	2,434,886	630	66.00
69.00	06900	ELECTROCARDIOLOGY	5,476,487	5,476,487	0	859,551	2,823	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,442,470	9,442,470	0	1,655,949	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,770,168	7,770,168	0	1,593,083	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,505,860	23,505,860	0	294,787	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	220,998	220,998	0	214,904	4,997	90.00
91.00	09100	EMERGENCY	42,392,496	42,392,496	0	4,626,017	5,301	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	2,182,076	2,182,076	0	1,575,029	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	258,650,519	258,650,519	-8,179,411	62,891,897	100,506	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7,332	372	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0	190.01
190.02	19002	SICK CHILD CARE	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	0	0	190.03
190.04	19004	ST. VINCENT'S STRESS	0	0	0	0	0	190.04
190.05	19005	MARKETING	0	0	0	424,456	192	190.05
190.06	19006	MHLIGHTBOUND	0	0	0	0	0	190.06
190.07	19007	I-74 CAMPUS	0	0	0	715,619	0	190.07
190.08	19008	SOUTHEAST OB	0	0	0	0	0	190.08
190.09	19009	INTELLI PLEX DEVELOPMENT	0	0	0	94,116	0	190.09
190.10	19010	MS&M	0	0	0	0	0	190.10
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	0	190.11
190.12	19012	BARTLEY ORTHOPEDICS	0	0	0	0	0	190.12
190.13	19013	SSA	0	0	0	0	0	190.13

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet B-1

Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description		ADMITTING (GROSS CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5.04	5.05	5A.06	5.06	7.00	
190.14	19014 SPORTSWORKS	0	0	0	0	0	190.14
190.15	19015 SHELBY PEDS	0	0	0	0	0	190.15
190.16	19016 RENOVO	0	0	0	48,626	0	190.16
190.17	19017 IMA	0	0	0	0	0	190.17
190.18	19018 MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019 MHCD	0	0	0	1,282,170	264	190.19
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 HOSPITALIST	0	0	0	2,504,748	0	192.01
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	1,092,438	2,551	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,474,609	1,769,252		8,179,411	2,927,055	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.005701	0.006840		0.118437	28.175916	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	33,240	654		212,164	231,617	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000129	0.000003		0.003072	2.229552	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet B-1
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00590	PURCHASING, RECEIVING, AND STORES					5.03
5.04	00570	ADMINISTRATIVE					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	389,185				8.00
9.00	00900	HOUSEKEEPING	0	103,073			9.00
10.00	01000	DIETARY	0	2,462	10,422		10.00
11.00	01100	CAFETERIA	0	3,899	0	840,273	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,683	0	30,336	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,181	0	0	14.00
15.00	01500	PHARMACY	0	1,448	0	23,095	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,203	0	35,517	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	150,256	24,273	9,336	191,114	30.00
31.00	03100	INTENSIVE CARE UNIT	23,350	7,433	1,086	39,559	31.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	54,242	9,738	0	85,523	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	471	0	19,069	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,261	9,293	0	62,231	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0	16,618	0	36,654	56.01
57.00	05700	CT SCAN	0	400	0	11,685	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	10,338	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	10,864	2,005	0	82,449	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	836	0	23,393	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	15,338	630	0	42,621	66.00
69.00	06900	ELECTROCARDIOLOGY	3,751	2,823	0	18,442	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,539	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,830	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	1,344	4,997	0	8,681	90.00
91.00	09100	EMERGENCY	82,645	5,301	0	78,400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	25,913	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	389,051	99,694	10,422	805,476	540,221
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	372	0	0	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	190.01
190.02	19002	SICK CHILD CARE	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	0	190.03
190.04	19004	ST. VINCENT'S STRESS	0	0	0	0	190.04
190.05	19005	MARKETING	0	192	0	6,148	190.05
190.06	19006	MH LIGHTBOUND	0	0	0	0	190.06
190.07	19007	I-74 CAMPUS	0	0	0	9,847	190.07
190.08	19008	SOUTHEAST OB	0	0	0	0	190.08
190.09	19009	INTELLI PLEX DEVELOPMENT	0	0	0	694	190.09
190.10	19010	MS&M	0	0	0	0	190.10
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	190.11
190.12	19012	BARTLEY ORTHOPEDICS	0	0	0	0	190.12
190.13	19013	SSA	0	0	0	0	190.13
190.14	19014	SPORTSWORKS	0	0	0	0	190.14

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet B-1

Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	
		8.00	9.00	10.00	11.00	13.00	
190.15	19015 SHELBY PEDS	0	0	0	0	0	190.15
190.16	19016 RENOV0	0	0	0	0	0	190.16
190.17	19017 IMA	0	0	0	0	0	190.17
190.18	19018 MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019 MHCD	0	264	0	0	0	190.19
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 HOSPITALIST	0	0	0	18,108	18,108	192.01
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	134	2,551	0	0	22,915	194.00
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)	283,975	1,723,384	591,205	808,593	1,849,335	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.729666	16.720033	56.726636	0.962298	3.125012	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	12,945	11,466	56,337	87,817	46,368	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.033262	0.111242	5.405584	0.104510	0.078353	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet B-1
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.01	01160				5.01
5.02	00550				5.02
5.03	00590				5.03
5.04	00570				5.04
5.05	00580				5.05
5.06	00592				5.06
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	100			14.00
15.00	01500	0	100		15.00
16.00	01600	0	0	261,318,885	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	0	0	17,873,550	30.00
31.00	03100	0	0	3,521,304	31.00
41.00	04100	0	0	0	41.00
42.00	04200	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0	0	34,022,961	50.00
52.00	05200	0	0	0	52.00
53.00	05300	0	0	1,214,478	53.00
54.00	05400	0	0	22,171,122	54.00
56.00	05600	0	0	0	56.00
56.01	05601	0	0	11,038,165	56.01
57.00	05700	0	0	20,376,214	57.00
58.00	05800	0	0	9,906,723	58.00
59.00	05900	0	0	0	59.00
60.00	06000	0	0	35,748,815	60.00
60.01	06001	0	0	0	60.01
65.00	06500	0	0	3,832,347	65.00
65.01	06501	0	0	4,069,354	65.01
66.00	06600	0	0	6,553,297	66.00
69.00	06900	0	0	5,476,487	69.00
71.00	07100	55	0	9,442,470	71.00
72.00	07200	45	0	7,770,168	72.00
73.00	07300	0	100	23,505,860	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	0	0	220,998	90.00
91.00	09100	0	0	42,392,496	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	0	0	0	95.00
97.00	09700	0	0	0	97.00
100.00	10000	0	0	0	100.00
101.00	10100	0	0	2,182,076	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	0	0	0	113.00
118.00		100	100	261,318,885	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
190.01	19001	0	0	0	190.01
190.02	19002	0	0	0	190.02
190.03	19003	0	0	0	190.03
190.04	19004	0	0	0	190.04
190.05	19005	0	0	0	190.05
190.06	19006	0	0	0	190.06
190.07	19007	0	0	0	190.07
190.08	19008	0	0	0	190.08
190.09	19009	0	0	0	190.09
190.10	19010	0	0	0	190.10
190.11	19011	0	0	0	190.11
190.12	19012	0	0	0	190.12
190.13	19013	0	0	0	190.13

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet B-1
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		14.00	15.00	16.00	
190.14	19014 SPORTSWORKS	0	0	0	190.14
190.15	19015 SHELBY PEDS	0	0	0	190.15
190.16	19016 RENOVO	0	0	0	190.16
190.17	19017 IMA	0	0	0	190.17
190.18	19018 MD SOLUTIONS	0	0	0	190.18
190.19	19019 MHCD	0	0	0	190.19
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01	19201 HOSPITALIST	0	0	0	192.01
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
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)	248,951	7,232,038	1,716,077	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2,489.510000	72,320.380000	0.006567	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	71,024	54,704	57,492	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	710.240000	547.040000	0.000220	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet C
Part I
Date/Time Prepared:
4/28/2016 3:20 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		12,456,667	0	12,456,667	30.00
31.00	03100 INTENSIVE CARE UNIT		2,773,503	0	2,773,503	31.00
41.00	04100 SUBPROVIDER - I RF		0	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		7,257,597	0	7,257,597	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY		1,733,330	152,964	1,886,294	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		6,253,363	0	6,253,363	54.00
56.00	05600 RADIOISOTOPE		0	0	0	56.00
56.01	05601 ONCOLOGY		3,875,727	4,829	3,880,556	56.01
57.00	05700 CT SCAN		1,356,226	0	1,356,226	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,044,747	0	1,044,747	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		6,550,583	0	6,550,583	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	1,581,411	0	1,581,411	65.00
65.01	06501 SLEEP LAB	0	913,474	0	913,474	65.01
66.00	06600 PHYSICAL THERAPY	0	2,846,794	1,448	2,848,242	66.00
69.00	06900 ELECTROCARDIOLOGY		1,202,175	0	1,202,175	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		2,054,413	0	2,054,413	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		1,947,541	0	1,947,541	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		7,716,102	0	7,716,102	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000 CLINIC		502,616	41,176	543,792	90.00
91.00	09100 EMERGENCY		6,071,038	373,976	6,445,014	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,252,863	0	1,252,863	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD		0	0	0	97.00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM		0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY		1,856,879	0	1,856,879	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		71,247,049	574,393	71,821,442	200.00
201.00	Less Observation Beds		1,252,863		1,252,863	201.00
202.00	Total (see instructions)		69,994,186	574,393	70,568,579	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 4/28/2016 3:20 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
	9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,905,470		14,905,470	30.00
31.00	03100	INTENSIVE CARE UNIT	3,521,304		3,521,304	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	41.00
42.00	04200	SUBPROVIDER	0		0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,432,287	25,590,674	34,022,961	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	276,677	937,801	1,214,478	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,419,206	19,751,916	22,171,122	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
56.01	05601	ONCOLOGY	28,116	11,010,049	11,038,165	56.01
57.00	05700	CT SCAN	3,213,876	17,162,338	20,376,214	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	956,980	8,949,743	9,906,723	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	7,393,082	28,355,733	35,748,815	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	3,149,062	683,285	3,832,347	65.00
65.01	06501	SLEEP LAB	9,892	4,059,462	4,069,354	65.01
66.00	06600	PHYSICAL THERAPY	1,039,640	5,513,657	6,553,297	66.00
69.00	06900	ELECTROCARDIOLOGY	674,874	4,801,613	5,476,487	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,886,311	6,556,159	9,442,470	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,035,036	3,735,132	7,770,168	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,580,426	15,925,434	23,505,860	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	202	220,796	220,998	90.00
91.00	09100	EMERGENCY	6,116,393	36,276,103	42,392,496	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,968,080	2,968,080	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	2,182,076	2,182,076	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	66,638,834	194,680,051	261,318,885	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	66,638,834	194,680,051	261,318,885	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 4/28/2016 3:20 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.213315		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	1.553173		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.282050		54.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
56.01	05601 ONCOLOGY	0.351558		56.01
57.00	05700 CT SCAN	0.066559		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.105458		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.183239		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.412648		65.00
65.01	06501 SLEEP LAB	0.224476		65.01
66.00	06600 PHYSICAL THERAPY	0.434627		66.00
69.00	06900 ELECTROCARDIOLOGY	0.219516		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.217572		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.250643		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.328263		73.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	2.460620		90.00
91.00	09100 EMERGENCY	0.152032		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.422112		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet C
Part I
Date/Time Prepared:
4/28/2016 3:20 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		12,456,667		0	12,456,667	30.00
31.00	03100 INTENSIVE CARE UNIT		2,773,503		0	2,773,503	31.00
41.00	04100 SUBPROVIDER - I RF		0		0	0	41.00
42.00	04200 SUBPROVIDER		0		0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		7,257,597		0	7,257,597	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0		0	0	52.00
53.00	05300 ANESTHESIOLOGY		1,733,330		152,964	1,886,294	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		6,253,363		0	6,253,363	54.00
56.00	05600 RADIOISOTOPE		0		0	0	56.00
56.01	05601 ONCOLOGY		3,875,727		4,829	3,880,556	56.01
57.00	05700 CT SCAN		1,356,226		0	1,356,226	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,044,747		0	1,044,747	58.00
59.00	05900 CARDIAC CATHETERIZATION		0		0	0	59.00
60.00	06000 LABORATORY		6,550,583		0	6,550,583	60.00
60.01	06001 BLOOD LABORATORY		0		0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	1,581,411		0	1,581,411	65.00
65.01	06501 SLEEP LAB	0	913,474		0	913,474	65.01
66.00	06600 PHYSICAL THERAPY	0	2,846,794		1,448	2,848,242	66.00
69.00	06900 ELECTROCARDIOLOGY		1,202,175		0	1,202,175	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		2,054,413		0	2,054,413	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		1,947,541		0	1,947,541	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		7,716,102		0	7,716,102	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC		0		0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	89.00
90.00	09000 CLINIC		502,616		41,176	543,792	90.00
91.00	09100 EMERGENCY		6,071,038		373,976	6,445,014	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,252,863		0	1,252,863	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES		0		0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD		0		0	0	97.00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM		0		0	0	100.00
101.00	10100 HOME HEALTH AGENCY		1,856,879		0	1,856,879	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)		71,247,049	0	574,393	71,821,442	200.00
201.00	Less Observation Beds		1,252,863			1,252,863	201.00
202.00	Total (see instructions)		69,994,186	0	574,393	70,568,579	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet C
Part I
Date/Time Prepared:
4/28/2016 3:20 pm

		Title XIX			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,905,470		14,905,470		30.00
31.00	03100	INTENSIVE CARE UNIT	3,521,304		3,521,304		31.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,432,287	25,590,674	34,022,961	0.213315	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	276,677	937,801	1,214,478	1.427222	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,419,206	19,751,916	22,171,122	0.282050	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
56.01	05601	ONCOLOGY	28,116	11,010,049	11,038,165	0.351121	56.01
57.00	05700	CT SCAN	3,213,876	17,162,338	20,376,214	0.066559	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	956,980	8,949,743	9,906,723	0.105458	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	7,393,082	28,355,733	35,748,815	0.183239	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	3,149,062	683,285	3,832,347	0.412648	65.00
65.01	06501	SLEEP LAB	9,892	4,059,462	4,069,354	0.224476	65.01
66.00	06600	PHYSICAL THERAPY	1,039,640	5,513,657	6,553,297	0.434406	66.00
69.00	06900	ELECTROCARDIOLOGY	674,874	4,801,613	5,476,487	0.219516	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,886,311	6,556,159	9,442,470	0.217572	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,035,036	3,735,132	7,770,168	0.250643	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,580,426	15,925,434	23,505,860	0.328263	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	202	220,796	220,998	2.274301	90.00
91.00	09100	EMERGENCY	6,116,393	36,276,103	42,392,496	0.143210	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,968,080	2,968,080	0.422112	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	2,182,076	2,182,076		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	66,638,834	194,680,051	261,318,885		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	66,638,834	194,680,051	261,318,885		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet C
Part I
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00	04200 SUBPROVIDER				42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
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
56.00	05600 RADIOISOTOPE	0.000000			56.00
56.01	05601 ONCOLOGY	0.000000			56.01
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
65.01	06501 SLEEP LAB	0.000000			65.01
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000			97.00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM				100.00
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150097		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part I Date/Time Prepared: 4/28/2016 3:20 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	PPS Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	664,828	0	664,828	10,380	64.05	30.00
31.00	INTENSIVE CARE UNIT	186,809		186,809	1,086	172.02	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
200.00	Total (lines 30-199)	851,637		851,637	11,466		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,445	284,702				
31.00	INTENSIVE CARE UNIT	560	96,331				
41.00	SUBPROVIDER - IRF	0	0				
42.00	SUBPROVIDER	0	0				
200.00	Total (lines 30-199)	5,005	381,033				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 4/28/2016 3:20 pm
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Cost Center Description		Title XVIII			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	267,260	34,022,961	0.007855	2,762,560	21,700	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	20,304	1,214,478	0.016718	82,231	1,375	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	238,136	22,171,122	0.010741	1,375,561	14,775	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
56.01	05601	ONCOLOGY	386,709	11,038,165	0.035034	24,584	861	56.01
57.00	05700	CT SCAN	20,810	20,376,214	0.001021	1,800,622	1,838	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,487	9,906,723	0.000756	497,274	376	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	85,760	35,748,815	0.002399	4,104,661	9,847	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	29,006	3,832,347	0.007569	1,477,739	11,185	65.00
65.01	06501	SLEEP LAB	5,231	4,069,354	0.001285	4,946	6	65.01
66.00	06600	PHYSICAL THERAPY	30,003	6,553,297	0.004578	677,049	3,100	66.00
69.00	06900	ELECTROCARDIOLOGY	70,992	5,476,487	0.012963	659,136	8,544	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,927	9,442,470	0.005076	1,641,457	8,332	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	39,896	7,770,168	0.005135	1,796,746	9,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	63,884	23,505,860	0.002718	3,847,816	10,458	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	112,944	220,998	0.005106	0	0	90.00
91.00	09100	EMERGENCY	165,999	42,392,496	0.003916	3,229,334	12,646	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	66,867	2,968,080	0.022529	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	1,659,215	240,710,035		23,981,716	114,269	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150097		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part III Date/Time Prepared: 4/28/2016 3:20 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
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
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	10,380	0.00	4,445	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,086	0.00	560	0		31.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
200.00		Total (lines 30-199)	11,466		5,005	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 4/28/2016 3:20 pm
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Cost Center Description		Title XVIII				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	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet D
Part IV
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description			Title XVIII			Hospital		PPS
			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	34,022,961	0.000000	0.000000	2,762,560	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,214,478	0.000000	0.000000	82,231	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,171,122	0.000000	0.000000	1,375,561	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
56.01	05601	ONCOLOGY	0	11,038,165	0.000000	0.000000	24,584	56.01
57.00	05700	CT SCAN	0	20,376,214	0.000000	0.000000	1,800,622	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	9,906,723	0.000000	0.000000	497,274	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	35,748,815	0.000000	0.000000	4,104,661	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	3,832,347	0.000000	0.000000	1,477,739	65.00
65.01	06501	SLEEP LAB	0	4,069,354	0.000000	0.000000	4,946	65.01
66.00	06600	PHYSICAL THERAPY	0	6,553,297	0.000000	0.000000	677,049	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,476,487	0.000000	0.000000	659,136	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,442,470	0.000000	0.000000	1,641,457	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	7,770,168	0.000000	0.000000	1,796,746	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,505,860	0.000000	0.000000	3,847,816	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	220,998	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	42,392,496	0.000000	0.000000	3,229,334	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,968,080	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	240,710,035			23,981,716	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 4/28/2016 3:20 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)	Hospital	PPS
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00		
50.00	05000 OPERATING ROOM	0	7,711,073	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	215,943	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,293,250	0		54.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
56.01	05601 ONCOLOGY	0	4,423,314	0		56.01
57.00	05700 CT SCAN	0	4,823,420	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2,207,380	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	3,751,135	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
65.00	06500 RESPIRATORY THERAPY	0	434,442	0		65.00
65.01	06501 SLEEP LAB	0	1,237,749	0		65.01
66.00	06600 PHYSICAL THERAPY	0	4,647	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	2,263,980	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,654,812	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,663,203	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,894,844	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	8,541,633	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	847,234	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
200.00	Total (lines 50-199)	0	51,968,059	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 4/28/2016 3:20 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	0.213315	7,711,073	0	0	1,644,888 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	1.427222	215,943	0	0	308,199 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.282050	5,293,250	0	0	1,492,961 54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0 56.00
56.01	05601 ONCOLOGY	0.351121	4,423,314	0	0	1,553,118 56.01
57.00	05700 CT SCAN	0.066559	4,823,420	0	0	321,042 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.105458	2,207,380	0	0	232,786 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00	06000 LABORATORY	0.183239	3,751,135	0	0	687,354 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
65.00	06500 RESPIRATORY THERAPY	0.412648	434,442	0	0	179,272 65.00
65.01	06501 SLEEP LAB	0.224476	1,237,749	0	0	277,845 65.01
66.00	06600 PHYSICAL THERAPY	0.434406	4,647	0	0	2,019 66.00
69.00	06900 ELECTROCARDIOLOGY	0.219516	2,263,980	0	0	496,980 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.217572	1,654,812	0	0	360,041 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.250643	1,663,203	0	0	416,870 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.328263	6,894,844	0	19,086	2,263,322 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				0 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0 89.00
90.00	09000 CLINIC	2.274301	0	0	0	0 90.00
91.00	09100 EMERGENCY	0.143210	8,541,633	0	0	1,223,247 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.422112	847,234	0	0	357,628 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.000000		0		0 95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0 97.00
200.00	Subtotal (see instructions)		51,968,059	0	19,086	11,817,572 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		51,968,059	0	19,086	11,817,572 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 4/28/2016 3:20 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
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
56.00	05600	RADIOISOTOPE	0	0	56.00
56.01	05601	ONCOLOGY	0	0	56.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	06501	SLEEP LAB	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,265	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
200.00		Subtotal (see instructions)	0	6,265	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	6,265	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 4/28/2016 3:20 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,380	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,380	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)		9,336	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)		4,445	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)		12,456,667	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)		12,456,667	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)		12,456,667	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,200.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,334,267	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)		5,334,267	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150097		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 4/28/2016 3:20 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)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	2,773,503	1,086	2,553.87	560	1,430,167		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)					5,649,444	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					12,413,878	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)					381,033	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					114,269	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					495,302	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					11,918,576	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,044	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,200.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,252,863	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150097		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 4/28/2016 3:20 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	664,828	12,456,667	0.053371	1,252,863	66,867	90.00
91.00	Nursing School cost	0	12,456,667	0.000000	1,252,863	0	91.00
92.00	Allied health cost	0	12,456,667	0.000000	1,252,863	0	92.00
93.00	All other Medical Education	0	12,456,667	0.000000	1,252,863	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 4/28/2016 3:20 pm
		Title XIX	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			10,380 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			10,380 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)			9,336 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)			438 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)			12,456,667 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)			12,456,667 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)			12,456,667 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,200.06 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			525,626 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)			525,626 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150097		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
Date/Time Prepared: 4/28/2016 3:20 pm		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	2,773,503	1,086	2,553.87	0	0		43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					379,904	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					905,530	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,044	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,200.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,252,863	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet D-1
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description	Cost	Title XIX		Hospital	Cost	
		Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	664,828	12,456,667	0.053371	1,252,863	66,867	90.00
91.00 Nursing School cost	0	12,456,667	0.000000	1,252,863	0	91.00
92.00 Allied health cost	0	12,456,667	0.000000	1,252,863	0	92.00
93.00 All other Medical Education	0	12,456,667	0.000000	1,252,863	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 4/28/2016 3:20 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		5,571,909	30.00
31.00	03100	INTENSIVE CARE UNIT		1,475,760	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.213315	2,762,560	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	1.553173	82,231	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.282050	1,375,561	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
56.01	05601	ONCOLOGY	0.351558	24,584	56.01
57.00	05700	CT SCAN	0.066559	1,800,622	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.105458	497,274	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.183239	4,104,661	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.412648	1,477,739	65.00
65.01	06501	SLEEP LAB	0.224476	4,946	65.01
66.00	06600	PHYSICAL THERAPY	0.434627	677,049	66.00
69.00	06900	ELECTROCARDIOLOGY	0.219516	659,136	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.217572	1,641,457	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.250643	1,796,746	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328263	3,847,816	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	2.460620	0	90.00
91.00	09100	EMERGENCY	0.152032	3,229,334	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.422112	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		23,981,716	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)		23,981,716	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 4/28/2016 3:20 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		1,059,599	30.00
31.00	03100	INTENSIVE CARE UNIT		147,978	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.213315	364,311	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	1.427222	23,602	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.282050	61,396	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
56.01	05601	ONCOLOGY	0.351121	581	56.01
57.00	05700	CT SCAN	0.066559	70,578	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.105458	21,364	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.183239	324,116	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.412648	113,922	65.00
65.01	06501	SLEEP LAB	0.224476	0	65.01
66.00	06600	PHYSICAL THERAPY	0.434406	11,898	66.00
69.00	06900	ELECTROCARDIOLOGY	0.219516	15,729	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.217572	161,225	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.250643	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328263	286,151	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	2.274301	0	90.00
91.00	09100	EMERGENCY	0.143210	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.422112	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		1,454,873	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,454,873	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 4/28/2016 3:20 pm
		Title XVIII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		6,217,862	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,125,992	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)		47,378	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		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		58.14	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)		4.40	30.00
31.00	Percentage of Medicaid patient days (see instructions)		20.00	31.00
32.00	Sum of lines 30 and 31		24.40	32.00
33.00	Allowable disproportionate share percentage (see instructions)		9.34	33.00
34.00	Disproportionate share adjustment (see instructions)		194,829	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 4/28/2016 3:20 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 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)		0.000054352	0.000051393	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		415,665	329,233	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		310,895	82,758	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		393,653		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)		8,979,714		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		8,979,714		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		668,316		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)		9,648,030		59.00
60.00	Primary payer payments		2,926		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		9,645,104		61.00
62.00	Deductibles billed to program beneficiaries		1,063,952		62.00
63.00	Coinurance billed to program beneficiaries		18,900		63.00
64.00	Allowable bad debts (see instructions)		44,171		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		28,711		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		44,171		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		8,590,963		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		31,696		70.93
70.94	HRR adjustment amount (see instructions)		-7,574		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet E
Part A
Date/Time Prepared:
4/28/2016 3:20 pm

		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2015	143,037		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)	2016	60,790		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)		8,818,912		71.00
71.01	Sequestration adjustment (see instructions)		176,378		71.01
72.00	Interim payments		8,580,528		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)		62,006		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1,722,671		75.00
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 1.00	On/After 10/1 2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/28/2016 3:20 pm

		Title XVIII		Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
	0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,217,862	0	6,217,862	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,125,992	0	0	2,125,992	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	47,378	0	44,760	2,618	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.01	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0934	0.0934	0.0934	0.0934	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	194,829	0	145,187	49,642	11.00
11.01	Uncompensated care payments	36.00	393,653	0	310,895	82,758	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	8,979,714	0	6,718,704	2,261,010	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,979,714	0	6,718,704	2,261,010	15.00
16.00	Payment for inpatient program capital	50.00	668,316	0	497,728	170,588	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/28/2016 3:20 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	7,216,432	2,431,598	9,648,030	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	667,835	0	497,348	170,487	667,835	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	481	0	380	101	481	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	668,316	0	497,728	170,588	668,316	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.019821	0.025000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			143,037		143,037	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				60,790	60,790	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Exhibit 5 Date/Time Prepared: 4/28/2016 3:20 pm
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		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,217,862	6,217,862		6,217,862	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,125,992		2,125,992	2,125,992	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	47,378	44,760	2,618	47,378	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0934	0.0934	0.0934		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	194,829	145,187	49,642	194,829	11.00
11.01	Uncompensated care payments	36.00	393,653	310,895	82,758	393,653	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	8,979,714	6,718,704	2,261,010	8,979,714	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,979,714	6,718,704	2,261,010	8,979,714	15.00
16.00	Payment for inpatient program capital	50.00	668,316	497,830	170,486	668,316	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			7,216,534	2,431,496	9,648,030	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
4/28/2016 3:20 pm

		Title XVIII			Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	667,835	497,349	170,486	667,835	20.00	
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01	
21.00	Capital DRG outlier payments	2.00	481	481	0	481	21.00	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	668,316	497,830	170,486	668,316	26.00	
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)					
		0	1.00	2.00	3.00	4.00		
27.00								27.00
28.00	Low volume adjustment prior to October 1	70.96	143,037	143,037		143,037	28.00	
29.00	Low volume adjustment on or after October 1	70.97	60,790		60,790	60,790	29.00	
30.00	HVBP payment adjustment (see instructions)	70.93	31,696	10,903	20,793	31,696	30.00	
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01	
31.00	HRR adjustment (see instructions)	70.94	-7,574	-3,109	-4,465	-7,574	31.00	
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01	
						(Amt. to Wkst. E, Pt. A)		
		0	1.00	2.00	3.00	4.00		
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 4/28/2016 3:20 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		6,265	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		11,817,572	2.00
3.00	PPS payments		9,715,825	3.00
4.00	Outlier payment (see instructions)		11,522	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		6,265	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		19,086	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)		19,086	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)		19,086	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		12,821	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		6,265	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		9,727,347	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,094,441	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		7,639,171	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		7,639,171	30.00
31.00	Primary payer payments		5,761	31.00
32.00	Subtotal (line 30 minus line 31)		7,633,410	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)		274,974	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		178,733	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		274,974	36.00
37.00	Subtotal (see instructions)		7,812,143	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-189	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		7,812,332	40.00
40.01	Sequestration adjustment (see instructions)		156,247	40.01
41.00	Interim payments		7,617,315	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		38,770	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: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet E-1
Part I
Date/Time Prepared:
4/28/2016 3:20 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		8,550,498		7,479,046	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	12/31/2015	30,030	12/31/2015	138,269	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)		30,030		138,269	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)		8,580,528		7,617,315	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		62,006		38,770	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		8,642,534		7,656,085	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: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet E-1
Part II
Date/Time Prepared:
4/28/2016 3:20 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	2,722	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	5,005	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,172	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	10,422	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	261,318,885	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	5,409,857	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 4/28/2016 3:20 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		905,530		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		905,530	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		905,530	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		1,207,577		8.00
9.00	Ancillary service charges		1,454,873	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		2,662,450	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		2,662,450	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,756,920	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		905,530	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		905,530	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		905,530	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		905,530	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		905,530	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		905,530	0	40.00
41.00	Interim payments		1,076,870	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-171,340	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet G

Date/Time Prepared:
4/28/2016 3:20 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	5,828,892	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	27,715,945	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-18,761,522	0	0	0	6.00
7.00	Inventory	11,298,452	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,020,480	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)	27,102,247	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,978,356	0	0	0	12.00
13.00	Land improvements	6,032,222	0	0	0	13.00
14.00	Accumulated depreciation	-2,110,875	0	0	0	14.00
15.00	Buildings	89,857,581	0	0	0	15.00
16.00	Accumulated depreciation	-22,924,128	0	0	0	16.00
17.00	Leasehold improvements	526,503	0	0	0	17.00
18.00	Accumulated depreciation	-484,349	0	0	0	18.00
19.00	Fixed equipment	868,356	0	0	0	19.00
20.00	Accumulated depreciation	-306,856	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	31,136,878	0	0	0	23.00
24.00	Accumulated depreciation	-25,613,241	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	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)	78,960,447	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	143,886,893	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	143,886,893	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	249,949,587	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,210,864	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,472,148	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,572,611	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,255,623	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	79,448,239	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	79,448,239	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	94,703,862	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	155,245,725				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)	155,245,725	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	249,949,587	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet G-1

Date/Time Prepared:
4/28/2016 3:20 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		118,595,754		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		36,649,971				2.00
3.00	Total (sum of line 1 and line 2)		155,245,725		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		155,245,725		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		155,245,725		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet G-2
Parts I & II
Date/Time Prepared:
4/28/2016 3:20 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	17,038,085		17,038,085	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	17,038,085		17,038,085	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,950,489		3,950,489	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)	3,950,489		3,950,489	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	20,988,574		20,988,574	17.00
18.00	Ancillary services	43,597,133	155,717,404	199,314,537	18.00
19.00	Outpatient services	6,116,595	36,496,899	42,613,494	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		2,182,076	2,182,076	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	MISC OTHER	2,935,459	6,089,365	9,024,824	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	73,637,761	200,485,744	274,123,505	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		86,557,748		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)		86,557,748		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150097

Period:
From 01/01/2015
To 12/31/2015

Worksheet G-3

Date/Time Prepared:
4/28/2016 3:20 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	274,123,505	1.00
2.00	Less contractual allowances and discounts on patients' accounts	155,294,604	2.00
3.00	Net patient revenues (line 1 minus line 2)	118,828,901	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	86,557,748	4.00
5.00	Net income from service to patients (line 3 minus line 4)	32,271,153	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 REVENUE	2,399,969	24.00
24.01	INVESTMENT INCOME	1,146,403	24.01
24.02	TRANSFERS	2,497,463	24.02
25.00	Total other income (sum of lines 6-24)	6,043,835	25.00
26.00	Total (line 5 plus line 25)	38,314,988	26.00
27.00	OTHER EXPENSES	1,665,017	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1,665,017	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	36,649,971	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150097

Period: From 01/01/2015 To 12/31/2015

Worksheet H

HHA CCN: 157418

Date/Time Prepared: 4/28/2016 3:20 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	134,344	56,548	0	0	190,283	381,175	5.00
HHA REIMBURSABLE SERVICES							
6.00	512,475	0	0	0	0	512,475	6.00
7.00	98	0	0	294,150	0	294,248	7.00
8.00	63,237	0	0	0	0	63,237	8.00
9.00	549	0	0	0	0	549	9.00
10.00	3,090	0	0	0	0	3,090	10.00
11.00	57,325	0	0	0	0	57,325	11.00
12.00	0	0	0	0	0	0	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
24.00	771,118	56,548	0	294,150	190,283	1,312,099	24.00
	Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	0	381,175	-478	380,697			5.00
HHA REIMBURSABLE SERVICES							
6.00	0	512,475	0	512,475			6.00
7.00	0	294,248	0	294,248			7.00
8.00	0	63,237	0	63,237			8.00
9.00	0	549	0	549			9.00
10.00	0	3,090	0	3,090			10.00
11.00	0	57,325	0	57,325			11.00
12.00	0	0	0	0			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
24.00	0	1,312,099	-478	1,311,621			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet H-1 Part I Date/Time Prepared: 4/28/2016 3:20 pm
		HHA CCN: 157418	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	380,697	0	0	0	380,697	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	512,475	0	0	0	512,475	6.00	
7.00	Physical Therapy	294,248	0	0	0	294,248	7.00	
8.00	Occupational Therapy	63,237	0	0	0	63,237	8.00	
9.00	Speech Pathology	549	0	0	0	549	9.00	
10.00	Medical Social Services	3,090	0	0	0	3,090	10.00	
11.00	Home Health Aide	57,325	0	0	0	57,325	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
24.00	Total (sum of lines 1-23)	1,311,621	0	0	0	1,311,621	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	380,697					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	209,574	722,049				6.00	
7.00	Physical Therapy	120,331	414,579				7.00	
8.00	Occupational Therapy	25,860	89,097				8.00	
9.00	Speech Pathology	225	774				9.00	
10.00	Medical Social Services	1,264	4,354				10.00	
11.00	Home Health Aide	23,443	80,768				11.00	
12.00	Supplies (see instructions)	0	0				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
24.00	Total (sum of lines 1-23)		1,311,621				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150097

Period: From 01/01/2015

Worksheet H-1

HHA CCN: 157418

To 12/31/2015

Part II
Date/Time Prepared:
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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-380,697	930,924
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	512,475
7.00	Physical Therapy	0	0	0	0	0	294,248
8.00	Occupational Therapy	0	0	0	0	0	63,237
9.00	Speech Pathology	0	0	0	0	0	549
10.00	Medical Social Services	0	0	0	0	0	3,090
11.00	Home Health Aide	0	0	0	0	0	57,325
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-380,697	930,924
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		380,697
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.408945

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150097

Period: From 01/01/2015 To 12/31/2015

Worksheet H-2 Part I

HHA CCN: 157418

Date/Time Prepared: 4/28/2016 3:20 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	DATA PROCESSING	PURCHASING, RECEIVING, AND STORES	
		BLDG & FIXT						
	0	1.00		4.00	5.01	5.02	5.03	
1.00 Administrative and General	0	0	0	153,025	0	74,696	8,322	1.00
2.00 Skilled Nursing Care	722,049	0	0	0	0	0	0	2.00
3.00 Physical Therapy	414,579	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	89,097	0	0	0	0	0	0	4.00
5.00 Speech Pathology	774	0	0	0	0	0	0	5.00
6.00 Medical Social Services	4,354	0	0	0	0	0	0	6.00
7.00 Home Health Aide	80,768	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	1,311,621	0	0	153,025	0	74,696	8,322	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.								21.00
Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE		
	5.04	5.05	5A.05	5.06	7.00	8.00		
1.00 Administrative and General	12,440	14,925	263,408	31,197	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	722,049	85,518	0	0	0	2.00
3.00 Physical Therapy	0	0	414,579	49,101	0	0	0	3.00
4.00 Occupational Therapy	0	0	89,097	10,552	0	0	0	4.00
5.00 Speech Pathology	0	0	774	92	0	0	0	5.00
6.00 Medical Social Services	0	0	4,354	516	0	0	0	6.00
7.00 Home Health Aide	0	0	80,768	9,566	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	12,440	14,925	1,575,029	186,542	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.000000					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150097

Period: From 01/01/2015

Worksheet H-2

HHA CCN: 157418

To 12/31/2015

Part I
Date/Time Prepared:
4/28/2016 3:20 pm

Home Health Agency I

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Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	80,978	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	80,978	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part I)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	14,330	389,913	0	389,913	0	0	1.00
2.00	Skilled Nursing Care	0	807,567	0	807,567	214,649	1,022,216	2.00
3.00	Physical Therapy	0	463,680	0	463,680	123,244	586,924	3.00
4.00	Occupational Therapy	0	99,649	0	99,649	26,486	126,135	4.00
5.00	Speech Pathology	0	866	0	866	230	1,096	5.00
6.00	Medical Social Services	0	4,870	0	4,870	1,294	6,164	6.00
7.00	Home Health Aide	0	90,334	0	90,334	24,010	114,344	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	14,330	1,856,879	0	1,856,879	389,913	1,856,879	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.265796		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150097
HHA CCN: 157418

Period:
From 01/01/2015
To 12/31/2015

Worksheet H-2
Part II
Date/Time Prepared:
4/28/2016 3:20 pm

Home Health Agency I

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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (TELEPHONES)	DATA PROCESSING (HARDWARE)	PURCHASING, RECEIVING, AND STORES (PURCHASING)	ADMITTING (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)							
	1.00	4.00						
1.00 Administrative and General	0	771,118	0	12	41,216	2,182,076	1.00	
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00 Physical Therapy	0	0	0	0	0	0	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19)	0	771,118	0	12	41,216	2,182,076	20.00	
21.00 Total cost to be allocated	0	153,025	0	74,696	8,322	12,440	21.00	
22.00 Unit cost multiplier	0.000000	0.198446	0.000000	6,224.666667	0.201912	0.005701	22.00	
Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)		
	5.05	5A.06	5.06	7.00	8.00	9.00		
1.00 Administrative and General	2,182,076	0	263,408	0	0	0	1.00	
2.00 Skilled Nursing Care	0	0	722,049	0	0	0	2.00	
3.00 Physical Therapy	0	0	414,579	0	0	0	3.00	
4.00 Occupational Therapy	0	0	89,097	0	0	0	4.00	
5.00 Speech Pathology	0	0	774	0	0	0	5.00	
6.00 Medical Social Services	0	0	4,354	0	0	0	6.00	
7.00 Home Health Aide	0	0	80,768	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19)	2,182,076	0	1,575,029	0	0	0	20.00	
21.00 Total cost to be allocated	14,925	0	186,542	0	0	0	21.00	
22.00 Unit cost multiplier	0.006840	0	0.118437	0.000000	0.000000	0.000000	22.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS		Provider CCN: 150097 HHA CCN: 157418	Period: From 01/01/2015 To 12/31/2015	Worksheet H-2 Part II Date/Time Prepared: 4/28/2016 3:20 pm PPS
		Home Health Agency I		

Cost Center Description	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
	10.00	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	0	0	25,913	0	0	2,182,076	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	25,913	0	0	2,182,076	20.00
21.00 Total cost to be allocated	0	0	80,978	0	0	14,330	21.00
22.00 Unit cost multiplier	0.000000	0.000000	3.124995	0.000000	0.000000	0.006567	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet H-3 Part I Date/Time Prepared: 4/28/2016 3:20 pm
		HHA CCN: 157418	Title XVIII	Home Health Agency I PPS

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation

1.00	Skilled Nursing Care	2.00	1,022,216		1,022,216	5,405	189.12	1.00
2.00	Physical Therapy	3.00	586,924	0	586,924	2,971	197.55	2.00
3.00	Occupational Therapy	4.00	126,135	0	126,135	739	170.68	3.00
4.00	Speech Pathology	5.00	1,096	0	1,096	13	84.31	4.00
5.00	Medical Social Services	6.00	6,164		6,164	70	88.06	5.00
6.00	Home Health Aide	7.00	114,344		114,344	1,403	81.50	6.00
7.00	Total (sum of lines 1-6)		1,856,879	0	1,856,879	10,601		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		Ratio (col. 3 ÷ col. 4)
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation

8.00	Skilled Nursing Care		26900	0	430			8.00
8.01	Skilled Nursing Care		50032	0	3,865			8.01
9.00	Physical Therapy		26900	0	123			9.00
9.01	Physical Therapy		50032	0	2,196			9.01
10.00	Occupational Therapy		26900	0	53			10.00
10.01	Occupational Therapy		50032	0	494			10.01
11.00	Speech Pathology		26900	0	4			11.00
11.01	Speech Pathology		50032	0	13			11.01
12.00	Medical Social Services		26900	0	2			12.00
12.01	Medical Social Services		50032	0	47			12.01
13.00	Home Health Aide		26900	0	159			13.00
13.01	Home Health Aide		50032	0	1,166			13.01
14.00	Total (sum of lines 8-13)			0	8,552			14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations

15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Part A	Program Visits		Cost of Services	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		6.00	7.00		8.00	9.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation

1.00	Skilled Nursing Care	0	4,295		0	812,270		1.00
2.00	Physical Therapy	0	2,319		0	458,118		2.00
3.00	Occupational Therapy	0	547		0	93,362		3.00
4.00	Speech Pathology	0	17		0	1,433		4.00
5.00	Medical Social Services	0	49		0	4,315		5.00
6.00	Home Health Aide	0	1,325		0	107,988		6.00
7.00	Total (sum of lines 1-6)	0	8,552		0	1,477,486		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150097

Period: From 01/01/2015

Worksheet H-3

HHA CCN: 157418

To 12/31/2015

Part I
Date/Time Prepared:
4/28/2016 3:20 pm

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Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of col s. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	812,270							1.00
2.00	Physical Therapy	458,118							2.00
3.00	Occupational Therapy	93,362							3.00
4.00	Speech Pathology	1,433							4.00
5.00	Medical Social Services	4,315							5.00
6.00	Home Health Aide	107,988							6.00
7.00	Total (sum of lines 1-6)	1,477,486							7.00
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150097 HHA CCN: 157418	Period: From 01/01/2015 To 12/31/2015	Worksheet H-3 Part II Date/Time Prepared: 4/28/2016 3:20 pm PPS
		Title XVIII	Home Health Agency I	

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.434406	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy					2.00
3.00	Speech Pathology					3.00
4.00	Cost of Medical Supplies	71.00	0.217572	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.328263	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 150097 HHA CCN: 157418	Period: From 01/01/2015 To 12/31/2015	Worksheet H-4 Part I-II Date/Time Prepared: 4/28/2016 3:20 pm
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	1,101,906
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	84,260
13.00	Total PPS Reimbursement - LUPA Episodes		0	10,989
14.00	Total PPS Reimbursement - PEP Episodes		0	2,490
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	21,854
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	1,221,499
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	1,221,499
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	1,221,499
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	1,221,499
30.00	OTHER		0	1
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
31.00	Subtotal (see instructions)		0	1,221,500
31.01	Sequestration adjustment (see instructions)		0	24,430
32.00	Interim payments (see instructions)		0	1,197,070
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 150097
HHA CCN: 157418

Period:
From 01/01/2015
To 12/31/2015

Worksheet H-5
Date/Time Prepared:
4/28/2016 3:20 pm
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		0		1,197,070	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			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			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. H-4, Part II, column as appropriate, line 32)		0		1,197,070	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		1,197,070	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 4/28/2016 3:20 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		667,835	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		481	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)		28.72	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)		668,316	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