In Lieu of Form CMS-2552-10 MAJOR HOSPITAL Health Financial Systems This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 Worksheet S HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 150097 Period: From 01/01/2015 Parts I-III Date/Time Prepared: 4/28/2016 3:25 pm AND SETTLEMENT SUMMARY То 12/31/2015 PART I - COST REPORT STATUS 1.[X] Electronically filed cost report Date: 4/28/2016 Time: 3:25 pm Provider use only]Manually submitted cost report 2.[] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. 3.[F 6. Date Received: 10.NPR Date: Contractor 5. [1]Cost Report Status 11.Contractor's Vendor Code: (1) As Submitted 7. Contractor No. use only (2) Settled without Audit 8. [N] Initial Report for this Provider CCN
 (3) Settled with Audit 9. [N] Final Report for this Provider CCN Settled with Audit (4) Reopened (5) Amended 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 OF 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. leen Encryption Information (Signed) h ECR: Date: 4/28/2016 Time: 3:25 pm Officer of Administrator of Provider(s) KGsCXrhAsCFZBSmvnEnqpr2ajJRnr0 Cho Yx31o0wtDwDCOn1KROiUAQBcn61mUH bvlj1HG1a206iHEW Title Date: 4/28/2016 Time: 3:25 pm PT: 5-2-2016 frI5eltnXWgzfqyftiRoCUb1cc4dM0 udKOsOdmxmg2dFZVNn83gYkrdj8lj1 Date ġ 0Drr0cHEQi0pDMQk Title XVIII Title V HIT Title XIX Part A Part B 3.00 4.00 5,00 1.00 2.00 PART III - SETTLEMENT SUMMARY -171,340 62,006 38,770 n 1.00 1.00 Hospital 0 0 2.00 2.00 Subprovider - IPF 0 0 0 3.00 Subprovider - IRF 0 0 0 0 3.00 0 0 4.00 SUBPROVIDER I 0 0 4.00 0 0 0 5.00 0 5.00 Swing bed - SNF 0 0 Swing bed - NF 6.00 0 6.00 9.00 HOME HEALTH AGENCY I 0 0 0 0 9.00 RURAL HEALTH CLINIC I 0 0 0 10.00 10.00 0 0 0 11.00 11.00 FEDERALLY QUALIFIED HEALTH CENTER I 62.006 38.770 -171.340 200.00 200.00 Total 0 0 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.

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02 03 00 00	for yes or "N" for no. Is this facil amendment hospital ?) In column 2, en Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per If this provider is an IPPS hospital in-state Medicaid paid days in col out-of-state Medicaid paid days in col out-of-state Medicaid and eligible unpaid 4, Medicaid HMO paid and eligible unpaid 4, Medicaid dHMO paid and eligible bup	ity subject to 42 ter "Y" for yes o compensated care es or "N" for no October 1. Enter eporting period o requires final u ? (see instructio e cost reporting no, for the porti ic reclassificati statistical area no for the portio 2, "Y" for yes or r after October 1 t more than 499 b t more than 499 b dicaid days on li f census days, or is cost reporting iod? In column 2 , enter the n 1, in-state umn 2, olumn 3, d days in column 4.	§412.106? CFR Sectio r "N" for n payments fo for the por in column 2 ccurring on ncompensate ns) Enter i period prio on of the co on from urb s adopted b n of the co "N" for no . (see inst eds (as cou " for no. nes 24 and/ 3 if date period dif <u>, enter "Y"</u> In-State Medicaid paid days <u>1.00</u>	In column n §412.066 o. r this cost tion of th r this cost tion of th r y"" for or after d care pay n column r to 0ctol ost report of to the p ructions) nted in ac for 25 belo of dischar ferent froc for yes co In-State Medicaid eligible unpaid days 2.00 1,086	1, er (c) (2) st rep he cos yes (Octob yments 1, "Y" ber 1. ting p portic Does ccorda ow? Ir rge. I Out the part of St Med paic	nter "Y" (Pickle porting st pr "N" per 1. s to be for ye Enter period on a resul ? Enter eriod on of th this ance wit n column s the e method (for no t-of ate (caid) d days 0 0	N N N N t N e h h Out-of State Medi cai d el i gi bl e unpai d 4.00	Medica HMO da	ai d ays 0 570	Y N N Ot dz	caid ays 00	22 22 22 23 23 23
02 03 00 00	for yes or "N" for no. Is this facil amendment hospital ?) In column 2, en Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per out-of-state Medicaid paid days in colum 4, Medicaid HMO paid and eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in RF, enter th	ity subject to 42 ter "Y" for yes o compensated care es or "N" for no October 1. Enter eporting period o requires final u ? (see instructio e cost reporting no, for the porti ic reclassificati statistical area no for the portio 2, "Y" for yes or r after October 1 t more than 499 b dicaid days on li f census days, or is cost reporting iod? In column 2 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state	§412.106? CFR Sectio r "N" for n payments fo for the por in column 2 ccurring on ncompensate ns) Enter i period prio on of the co "N" for no. (see inst eds (as cou " for no. nes 24 and/ 3 if date period dif , enter "Y" In-State Medicaid paid days 1.00	In column in §412.066 io. ir this cost tion of th t, "Y" for or after d care pay in column or to Octol cost report streportions) inted in action for the p ructions) inted in action for ges control for yes control for yes control legisle unpaid days 2.00	1, er (c) (2) st rep he cos yes (Octob yments 1, "Y" ber 1. ting p portic Does ccorda ow? Ir rge. I Out the part of St Med paic	nter "Y" (Pickle porting st pr "N" per 1. s to be i for ye Enter period on of th this ance wit n column s the e method i for no t-of ate i caid I days 	N S N S N t N C UUT-OF State Medi cai d el i gi bl e unpai d 4. 00	Medica HMO da	aid ays D	Y N N Ot dz	caid ays 00	22 22 22 23 23 23
02 03 00 00	for yes or "N" for no. Is this facil amendment hospital ?) In column 2, en Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per If this provider is an IPPS hospital in-state Medicaid paid days in col out-of-state Medicaid paid days in col out-of-state Medicaid and eligible unpaid 4, Medicaid HMO paid and eligible unpaid 4, Medicaid dHMO paid and eligible bup	ity subject to 42 ter "Y" for yes o compensated care es or "N" for no October 1. Enter eporting period o requires final u ? (see instructio e cost reporting no, for the porti ic reclassificati statistical area no for the porti 2, "Y" for yes or r after October 1 t more than 499 b "Y" for yes or "N dicaid days on li f census days, or is cost reporting iod? In column 2 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state	§412.106? CFR Sectio r "N" for n payments fo for the por in column 2 ccurring on ncompensate ns) Enter i period prio on of the co on from urb s adopted b n of the co "N" for no . (see inst eds (as cou " for no. nes 24 and/ 3 if date period dif <u>, enter "Y"</u> In-State Medicaid paid days <u>1.00</u>	In column n §412.066 o. r this cost tion of th r this cost tion of th r y"" for or after d care pay n column r to 0ctol ost report of to the p ructions) nted in ac for 25 belo of dischar ferent froc for yes co In-State Medicaid eligible unpaid days 2.00 1,086	1, er (c) (2) st rep he cos yes (Octob yments 1, "Y" ber 1. ting p portic Does ccorda ow? Ir rge. I Out the part of St Med paic	nter "Y" (Pickle porting st pr "N" per 1. s to be for ye Enter period on a resul ? Enter eriod on of th this ance wit n column s the e method (for no t-of ate (caid) d days 0 0	N N N N t N e h h Out-of State Medi cai d el i gi bl e unpai d 4.00	Medica HMO da	ai d ays 0 570	Y N N Ot dz	caid ays 00	22 22 22 23 23 23
03	for yes or "N" for no. Is this facil amendment hospital ?) In column 2, en Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per out-of-state Medicaid paid days in colum 4, Medicaid eligible unpaid days in colum 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in lf this provider is an IRF, enter th Medicaid paid days in column 1, the	ity subject to 42 ter "Y" for yes o compensated care es or "N" for no October 1. Enter eporting period o requires final u ? (see instructio e cost reporting no, for the porti ic reclassificati statistical area no for the portio 2, "Y" for yes or r after October 1 t more than 499 b "Y" for yes or "N dicaid days on li f census days, or is cost reporting iod? In column 2 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state umn 2,	§412.106? CFR Sectio r "N" for n payments fo for the por in column 2 ccurring on ncompensate ns) Enter i period prio on of the co on from urb s adopted b n of the co "N" for no . (see inst eds (as cou " for no. nes 24 and/ 3 if date period dif <u>, enter "Y"</u> In-State Medicaid paid days <u>1.00</u>	In column n §412.066 o. r this cost tion of th r this cost tion of th r y"" for or after d care pay n column r to 0ctol ost report of to the p ructions) nted in ac for 25 belo of dischar ferent froc for yes co In-State Medicaid eligible unpaid days 2.00 1,086	1, er (c) (2) st rep he cos yes (Octob yments 1, "Y" ber 1. ting p portic Does ccorda ow? Ir rge. I Out the part of St Med paic	nter "Y" (Pickle porting st pr "N" per 1. s to be for ye Enter period on a resul ? Enter eriod on of th this ance wit n column s the e method (for no t-of ate (caid) d days 0 0	N N N N t N e h h Out-of State Medi cai d el i gi bl e unpai d 4.00	Medica HMO da	ai d ays 0 570	Y N N Ot dz	caid ays 00	22 22 22 23 23 23 23
02 03 00 00	for yes or "N" for no. Is this facil amendment hospital ?) In column 2, en Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per out-of-state Medicaid paid days in colum 4, Medicaid eligible unpaid and eligible unpai 4, Medicaid HMO paid and eligible unpai 4, Medicaid days in column 1, the Medicaid paid days in column 1, the Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	ity subject to 42 ter "Y" for yes o compensated care es or "N" for no October 1. Enter eporting period o requires final u ? (see instructio e cost reporting no, for the porti ic reclassificati statistical area no for the porti ic reclassificati statistical area no for the porti of, "Y" for yes or r after October 1 t more than 499 b "Y" for yes or "N dicaid days on li f census days, or is cost reporting iod? In column 2 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in colum 6. e in-state in-state umn 2, 3, out-of-state	§412.106? CFR Sectio r "N" for n payments fo for the por in column 2 ccurring on ncompensate ns) Enter i period prio on of the co on from urb s adopted b n of the co "N" for no . (see inst eds (as cou " for no. nes 24 and/ 3 if date period dif <u>, enter "Y"</u> In-State Medicaid paid days <u>1.00</u>	In column n §412.066 o. r this cost tion of th r this cost tion of th r y"" for or after d care pay n column r to 0ctol ost report of to the p ructions) nted in ac for 25 belo of dischar ferent froc for yes co In-State Medicaid eligible unpaid days 2.00 1,086	1, er (c) (2) st rep he cos yes (Octob yments 1, "Y" ber 1. ting p portic Does ccorda ow? Ir rge. I Out the part of St Med paic	nter "Y" (Pickle porting st pr "N" per 1. s to be for ye Enter period on a resul ? Enter eriod on of th this ance wit n column s the e method (for no t-of ate (caid) d days 00 0	N N N N t N e h h Out-of State Medi cai d el i gi bl e unpai d 4.00	Medica HMO da	ai d ays 0 570	Y N N Ot dz	caid ays 00	22 22 22 23 23 23

	Financial Systems		JOR HOS	SPI TAL		1	n Lie	u of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICAT	ION DAT	ГА	Provi de	F	Period: From 01/01, To 12/31,		Workshe Part I Date/Ti 4/28/20	me Pre	pared:
						Urban/Rui 1.00			Geogr	
	Enter your standard geographic classification (eginning of the		1	2.0		26.00
27.00	cost reporting period. Enter "1" for urban or " Enter your standard geographic classification (reporting period. Enter in column 1, "1" for ur	(not wag rban or	ge) sta "2" fo	atus at the e or rural. If	nd of the cost applicable,		1			27.00
	enter the effective date of the geographic recl If this is a sole community hospital (SCH), ent effect in the cost reporting period.				SCH status in		0			35.00
						Begi nni 1. 00		Endi ı 2. C		
36.00	Enter applicable beginning and ending dates of			Subscript lin	e 36 for number			2.0		36.00
	of periods in excess of one and enter subsequer If this is a Medicare dependent hospital (MDH), is in effect in the cost reporting period.			umber of peri	ods MDH status		0			37.00
	If line 37 is 1, enter the beginning and ending greater than 1, subscript this line for the num enter subsequent dates.									38.00
						Y/N		Y/I 2. C		
	Does this facility qualify for the inpatient ho					1.00 Y		2. U Y		39.00
	hospitals in accordance with 42 CFR §412.101(b) or "N" for no. Does the facility meet the miles CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" fo Is this hospital subject to the HAC program rec "N" for no in column 1, for discharges prior to	age requestor yes of duction	ui remer or "N" adj ust	nts in accord for no. (see tment? Enter	ance with 42 instructions) "Y" for yes or	N		N		40.00
	no in column 2, for discharges on or after Octo	ober 1.	(see i	nstructions)			V	XVIII	XIX	
							1.00		3.00	
45.00	<u>Prospective Payment System (PPS)-Capital</u> Does this facility qualify and receive Capital		t for d	disproportion	ate share in ac	cordance	N	N	N	45.00
46.00	with 42 CFR Section §412.320? (see instructions Is this facility eligible for additional paymer pursuant to 42 CFR §412.348(f)? If yes, complet	nt exce	ption f . L, Pi	for extraordi t. III and Wk	nary circumstan st. L-1, Pt. I	ces through	N	N	N	46.00
47.00	Pt. III. Is this a new hospital under 42 CFR §412.300 PF Is the facility electing full federal capital p						N N	N N	N N	47.00 48.00
56.00	Teaching Hospitals Is this a hospital involved in training resider	nts in a	approve	ed GME progra	ms? Enter "Y"	for yes	N			56.00
57 00	or "N" for no. If line 56 is yes, is this the first cost repor	ctina n	eriod o	turing which	residents in an	nroved				57.00
	GME programs trained at this facility? Enter " is "Y" did residents start training in the firs for yes or "N" for no in column 2. If column 2 "N", complete Wkst. D, Parts III & IV and D-2,	'Y" for st montl 2 is "Y Pt. II	yes or h of th ", comp , if ap	r "N" for no nis cost repo plete Workshe pplicable.	in column 1. If rting period? et E-4. If colu	column 1 Enter "Y" mn 2 is				
	If line 56 is yes, did this facility elect cost defined in CMS Pub. 15-1, chapter 21, §2148? If				ians' services	as	N			58.00
	Are costs claimed on line 100 of Worksheet A? Are you claiming nursing school and/or allied h						N N			59.00 60.00
	provider-operated criteria under §413.85? Ente		for yes	s or "N" for	<u>no. (see instru</u>	<u>ctions)</u>				00.00
			Y/N	IME	Direct GME	IME		Di rect	GME	
61 00	Did your hospital receive FTE slots under ACA		1.00 N	2.00	3.00	4.00) 0. 00	5. C		61.00
	section 5503? Enter "Y" for yes or "N" for no i column 1. (see instructions)						0.00		0.00	
	Enter the average number of unweighted primary FTEs from the hospital's 3 most recent cost rep ending and submitted before March 23, 2010. (se	ports		0.	00 O. C					61.01
61. 02	instructions) Enter the current year total unweighted primary FTE count (excluding OB/GYN, general surgery FT and primary care FTEs added under section 5503	, TEs,		0.	00 O. C	IO				61. 02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is usec	d for		0.	oo o. c	ic				61. 03
61.04	determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in t			0.	00 0. C	0				61. 04
61. 05	current cost reporting period. (see instructions Enter the difference between the baseline prima and/or general surgery FTEs and the current yea	s). ary ar's		0.	00 O. C	o				61.05
61.06	primary care and/or general surgery FTE counts 61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is bei used for cap relief and/or FTEs that are nonpri care or general surgery. (see instructions)	ng		0.	od o. c	o				61.06

IOSPI TAL ANI	D HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DA	TA Provi der		eriod: rom 01/01/2015 o 12/31/2015	Worksheet S-2 Part I Date/Time Pre 4/28/2016 3:20	pared:
			Program Name	Program Code		Direct GME FTE Count	
1 10 00		C	1.00	2.00	3.00	4.00	1
speci for e colum progr unwei FTE u 1.20 Of th progr resid instr enter 3, th	e FTEs in line 61.05, speci alty, if any, and the numbe ach new program. (see instr n 1, the program name, ente am code, enter in column 3, ghted count and enter in co nweighted count. e FTEs in line 61.05, speci am specialty, if any, and t lents for each expanded prog uctions) Enter in column 1, in column 2, the program c e IME FTE unweighted count rect GME FTE unweighted cou	r of FTE residents uctions) Enter in r in column 2, the the IME FTE lumn 4, direct GME fy each expanded he number of FTE ram. (see the program name, ode, enter in column and enter in column			0.00		61. 1
						1.00	-
ACA P	rovisions Affecting the Hea	th Resources and Ser	vices Administration	(HRSA)		1.00	
	the number of FTE resident				od for which	0.00	62. C
	hospital received HRSA PCRE					0.00	
duri n	the number of FTE resident <u>g in this cost reporting pe</u> ing Hospitals that Claim Re	riod of HRSA THC prog	<u>ıram. (see instructio</u>		your nospi tai	0.00	62.0
3.00 Has y	our facility trained reside for yes or "N" for no in col	nts in nonprovider se	ttings during this c	instructions)		N	63.0
				Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der Si te	Hospi tal	2))	
	5504 0 H 104 D Y			1.00	2.00	3.00	
	on 5504 of the ACA Base Yea d that begins on or after J			This base year	is your cost r	eporting	
4.00 Enter in th resid setti resid	in column 1, if line 63 is e base year period, the num lent FTEs attributable to ro ngs. Enter in column 2 the lent FTEs that trained in yo olumn 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweightec ur hospital. Enter in	y trained residents -primary care all nonprovider I non-primary care column 3 the ratio instructions)	0.00			
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te		Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
is ye train year assoc FTEs progr resid the p colum unwei resid rotat non-p colum unwei resid your	in column 1, if line 63 s, or your facility ed residents in the base period, the program name iated with primary care for each primary care am in which you trained ents. Enter in column 2, rogram code, enter in n 3, the number of ghted primary care FTE ents attributable to ions occurring in all rovider settings. Enter in n 4, the number of ghted primary care ent FTEs that trained in hospital. Enter in column e ratio of (column 3			0.00	0.00	0. 000000	

Health Financial Systems		AJOR HOSPI TAL				eu of Form CMS-:	
HOSPITAL AND HOSPITAL HEALTH CARE COI	IPLEX I DENTIFICATION DA	ATA I	Provi der	F	Period: From 01/01/2015 Fo 12/31/2015		pared:
		i		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Curren	t Year FTE Residents i	n Nonprovider	Setting	1.00 sEffective f	2.00 for cost report	3.00 ing periods	
66.00 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hosp (column 1 divided by (column 1	f unweighted non-prima occurring in all nonp f unweighted non-prima tal. Enter in column 3	rovider setti ry care resid 3 the ratio o	ngs. ent	0.0	0 0.0	0. 000000	66.00
	Program Name	Program	Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	l -	3.00	4.00	5.00	(7.00
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 attributabl to rotations occurring in all non-provider settings. Enter i column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions)	9			0.0	0 0.0	0. 000000	67.00
					1.0		
Inpatient Psychiatric Facility	PPS				1.0	0 2.00 3.00	
70.00 Is this facility an Inpatient		IPF), or does	it conta	ain an IPF sub	provider? N		70.00
Enter "Y" for yes or "N" for 71.00 If line 70 yes: Column 1: Did recent cost report filed on or 42 CFR 412.424(d)(1)(iii)(c)) program in accordance with 42 Column 3: If column 2 is Y, in (see instructions) Inpatient Rehabilitation Facil	the facility have an ap before November 15, 20 Column 2: Did this faci CFR 412.424 (d)(1)(iii) dicate which program ye	004? Enter " ility train r)(D)? Enter "	Y" for ye esidents Y" for ye	es or "N" for in a new teac es or "N" for	no. (see hing no.	0	71.00
75.00 Is this facility an Inpatient	Rehabilitation Facilit	y (IRF), or d	oes it co	ontain an IRF	N		75.00
<pre>subprovider? Enter "Y" for ye 76.00 If line 75 yes: Column 1: Did recent cost reporting period e no. Column 2: Did this facilit CFR 412.424 (d)(1)(iii)(D)? En indicate which program year be</pre>	the facility have an ap nding on or before Nove y train residents in a ter "Y" for yes or "N"	ember 15, 200 new teaching for no. Colu	4? Enter program mn 3: lf	"Y" for yes o in accordance column 2 is Y	with 42	0	76.00
						1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospi 81.00 Is this a LTCH co-located with					period? Enter	N N	80. 00 81. 00
"Y" for yes and "N" for no. TEFRA Providers	•	•				N	85.00
 85.00 Is this a new hospital under 4 86.00 Did this facility establish a §413.40(f)(1)(ii)? Enter "Y" 	new Other subprovider for yes and "N" for no.	(excluded uni	t) under	42 CFR Sectio	n	N	85.00
87.00 Is this hospital a "subclause for yes or "N" for no.	(II)" LTCH classified (under section	1886(d)	(1)(B)(iv)(II)		N	87.00
					V 1.00	XI X 2.00	
Title V and XIX Services90.00Does this facility have title		hospital ser	vi ces? Er	nter "Y" for	N	Y	90.00
yes or "N" for no in the appli 91.00 Is this hospital reimbursed fo	r title V and/or XIX t				Ν	Ν	91.00
full or in part? Enter "Y" for 92.00 Are title XIX NF patients occu						N	92.00
instructions) Enter "Y" for ye 93.00 Does this facility operate an	s or "N" for no in the CF/IID facility for p	applicable c	olumn.	, ,	N	Ν	93.00
"Y" for yes or "N" for no in t 94.00 Does title V or XIX reduce cap applicable column.		or yes, and "	N" for no	o in the	Ν	Ν	94.00

Health Financial Systems MAJOR HOSPITAL		I r	n Lieu	of Form CN	IS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider	CCN: 150097	Period: From 01/01/ To 12/31/		Worksheet S Part I Date/Time I	Prepared:
		V		4/28/2016 3 XI X	3:20 pm
95.00 If line 94 is "Y", enter the reduction percentage in the applicable column 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for ne		1.00 N	0. 00	2.00 0 N	. 00 95. 00 96. 00
applicable column. 97.00 <u>If line 96 is "Y", enter the reduction percentage in the applicable column</u>	n.		0.00	0	. 00 97. 00
Rural Providers 105.00 Does this hospital qualify as a critical access hospital (CAH)? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive meth	hod of paymer	nt N			105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement training programs? Enter "Y" for yes or "N" for no in column 1. (see instru- yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the p	ructions) If				107.00
reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee scher CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	dule? See 42				108.00
Physical 109.00 1f 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	Occupationa 2.00 N	al Speech 3.00 N		Respirator 4.00 N	<u>109.00</u>
Tor yes of N for no for each therapy.	1			1 00	_
110.00 Did this hospital participate in the Rural Community Hospital Demonstration the current cost reporting period? Enter "Y" for yes or "N" for no.	on project (4	10A Demo)for		1.00 N	110.00
			1.00	2.00 3.0	00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in is yes, enter the method used (A, B, or E only) in column 2. If column 2 3 either "93" percent for short term hospital or "98" percent for long te	is "E", enter rm care (incl	in column udes	N	C	115.00
psychiatric, rehabilitation and long term hospitals providers) based on the Pub.15-1, chapter 22, §2208.1. 116.00 s 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 " no. 118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1	5		Y 1		117.00
claim-made. Enter 2 if the policy is occurrence.	Premiums	Losses		Insurance	
119 01 list amounts of malarastica promiums and paid losses	1.00	2.00	0	3.00	0119.01
118.01 List amounts of malpractice premiums and paid losses:	215, 6		0		0 118. 01
118.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing c		1.00 N		2.00	118. 02
and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions)	" for yes or he Outpatient			Ν	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00Did this facility incur and report costs for high cost implantable device: patients? Enter "Y" for yes or "N" for no.	s charged to	Y			121.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"	for no. If	N			125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certi- in column 1 and termination date, if applicable, in column 2.	fication date	9			126.00
127.00 If this is a Medicare certified heart transplant center, enter the certifin column 1 and termination date, if applicable, in column 2.	ication date				127.00
128.00 If this is a Medicare certified liver transplant center, enter the certified in column 1 and termination date, if applicable, in column 2.	ication date				128.00
129.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.	cation date i	n			129. 00
130.00 If this is a Medicare certified pancreas transplant center, enter the cer date in column 1 and termination date, if applicable, in column 2.	ti fi cati on				130. 00
131.00 If this is a Medicare certified intestinal transplant center, enter the conduction of the second sec	erti fi cati on				131.00
132.00 If this is a Medicare certified islet transplant center, enter the certified is a medicare certified islet transplant center, enter the certified is a medicare certified is a contract of the certified is a medicare certified is a contract of the certified is a medicare certified is a medicare certified is a contract of the certified is a medicare certified	ication date				132.00
133.00 If this is a Medicare certified other transplant center, enter the certif in column 1 and termination date, if applicable, in column 2.	ication date				133.00
134.00 If this is an organ procurement organization (OPO), enter the OPO number and termination date, if applicable, in column 2.	in column 1				134.00

Health Financial Systems		HOSPI TAL			In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX II			CCN: 150097			Worksheet S-2 Part I Date/Time Pre 4/28/2016 3:2	pared:
					1.00	2.00	-
All Providers					1.00	2.00	
140.00 Are there any related organization or chapter 10? Enter "Y" for yes or "N" are claimed, enter in column 2 the ho	for no in column 1. I	If yes, and home	office costs	;	Ν		140.00
		. 00			3.00		
If this facility is part of a chain o				name and	d address	of the	
home office and enter the home office 141.00Name:	contractor name and Contractor's Name:	contractor numb	oer. Contract	or's Nu	mbor		141.00
141.00 Name: 142.00 Street:	PO Box:		Contract	or S Nu	iliber:		141.00
143. 00 Ci ty:	State:		Zip Code	:			143.00
144 00 Are provider based physicians' costs	included in Werksheet	+ 12				1.00 Y	144.00
144.00 Are provider based physicians' costs	THET UDEN THE WOLKSHEE					T	144.00
					1.00	2.00	
145.00 If costs for renal services are claim inpatient services only? Enter "Y" fo no, does the dialysis facility includ period? Enter "Y" for yes or "N" for	r yes or "N" for no i e Medicare utilizatio no in column 2.	in column 1. If on for this cost	column 1 is reporting		N		145.00
146.00 Has the cost allocation methodology c Enter "Y" for yes or "N" for no in co yes, enter the approval date (mm/dd/y	hanged from the previ Lumn 1. (See CMS Pub.	iously filed cos 15-2, chapter	t report? 40, §4020) If	-	N		146.00
						1.00	-
147.00 Was there a change in the statistical	basis? Enter "Y" for	r ves or "N" for	no.			N 1.00	147.00
148.00 Was there a change in the order of al						N	148.00
149.00 Was there a change to the simplified	cost finding method?					N	149.00
		Part A 1.00	Part B 2.00	I	itle V 3.00	Title XIX 4.00	-
Does this facility contain a provider	that qualifies for a			ation of			
or charges? Enter "Y" for yes or "N"					2 CFR §413	. 13)	
155.00Hospital 156.00Subprovider - IPF		N	N		N	N	155.00 156.00
156. 00 Subprovider – TPF 157. 00 Subprovider – TRF		N	N N		N N	N N	156.00
158. 00 SUBPROVI DER							158.00
159.00 SNF		N	N		Ν	N	159.00
160.00 HOME HEALTH AGENCY		N	N		N	N	160.00
161.00 CMHC			N		N	N	161.00
						1.00	
Multicampus							
165.00 Is this hospital part of a Multicampu Enter "Y" for yes or "N" for no.	s hospital that has o	one or more camp	uses in diffe	erent CB	SAs?	N	165.00
	Name	County	State Zi	p Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						0.00	166.00
column 5 (see instructions)							
						1.00	-
Health Information Technology (HIT) i				nt Act			
167.00 Is this provider a meaningful user un 168.00 If this provider is a CAH (line 105 i reasonable cost incurred for the HIT	s "Y") and is a meani	ingful user (lin		, enter	the	Y C	167.00 168.00
168.01 If this provider is a CAH and is not					lshi p		168. 01
exception under §413.70(a)(6)(ii)? En 169.00 If this provider is a meaningful user transition factor. (see instructions)					nter the	9.99	169.00
				Be	gi nni ng	Endi ng	
170.00 Enter in columns 1 and 2 the EHR begi period respectively (mm/dd/yyyy)	nning date and ending	g date for the r	eporti ng	01/	<u>1.00</u> ′01/2015	2.00 12/31/2015	170.00

Health Financial Systems	MAJOR HOSPI TA	L		In Lie	u of Form CMS	6-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA	Provider CCN:	150097	Period: From 01/01/2015 To 12/31/2015		repared:
					1.00	
171.00 If line 167 is "Y", does this provider have any day Medicare cost plans reported on Wkst. S-3, Pt. I, I (see instructions)					Ν	171.00

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE Provi der		Period: From 01/01/2015 To 12/31/2015	Date/Time Pr	repared
				Y/N	4/28/2016 3: Date	20 pm
				1.00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for all NO re	esponses. Ente	r all dates in t	the	
	Provider Organization and Operation		++	N		
00	Has the provider changed ownership immediated reporting period? If yes, enter the date of the second			N		1.
			Y/N	Date	V/I	
00	lles the provider terminated participation in	the Medieere Dreaner? If	1.00 N	2.00	3.00	2.
0	Has the provider terminated participation in yes, enter in column 2 the date of termination		IN			2.
20	voluntary or "I" for involuntary.		N			
00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or to relationships? (see instructions)	, chain home offices, drug d to the provider or its , or members of the board	N			3.
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	
00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Compiled, enter date available in	Y	A		4.
00	column 3. (see instructions) If no, see instr Are the cost report total expenses and total		N			5.
	those on the filed financial statements? If	yes, submit reconciliation.		× (1)		
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
00	Column 1: Are costs claimed for nursing scho	ool?Column 2: If yes, is th	ne provider is	N		6.
0	the legal operator of the program? Are costs claimed for Allied Health Programs?	? If "Y" see instructions.		N		7.
00	Were nursing school and/or allied health prog	grams approved and/or renewed	d during the	N		8.
0	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents i		ral education	N		9.
0	program in the current cost report? If yes,					
00	Was an approved Intern and Resident GME progr cost reporting period? If yes, see instruction		the current	N		10.
00	Are GME cost directly assigned to cost center		proved	N		11.
	Teaching Program on Worksheet A? If yes, see	instructions.				_
					Y/N 1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bac			ot poporting	Y	12.
00	If line 12 is yes, did the provider's bad del period? If yes, submit copy.	of collection policy change of	suring this co	st reporting	N	13.
	If line 12 is yes, were patient deductibles a	and/or co-payments waived? I1	fyes, see ins	tructions.	N	14.
00						
	Bed Complement	pr cost roporting poriod2 [f	vos soo inst	ructions		15
	Bed Complement Did total beds available change from the price	or cost reporting period? If	f	ructions. Irt A	N Part B	15.
		Description	Pa Y/N	nt A Date	Part B Y/N	15.
	Did total beds available change from the pric		Pa	rt A	Part B	15.
00	Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R	Description	Pa Y/N	nt A Date	Part B Y/N	
00	Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes,	Description	Pa Y/N 1.00	Date 2.00	Part B Y/N 3.00	
00	Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R	Description	Pa Y/N 1.00	Date 2.00	Part B Y/N 3.00	
00	Did total beds available change from the prior PS&R Data 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)	Description	Pa Y/N 1.00 Y	Date 2.00	Part B Y/N 3.00 Y	16.
00	Did total beds available change from the prio PS&R Data 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) Was the cost report prepared using the PS&R	Description	Pa Y/N 1.00	Date 2.00	Part B Y/N 3.00	16.
00	Did total beds available change from the prior PS&R Data 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) 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	Description	Pa Y/N 1.00 Y	Date 2.00	Part B Y/N 3.00 Y	16.
00	Did total beds available change from the price PS&R Data 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) 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	Description	Pa Y/N 1.00 Y	Date 2.00	Part B Y/N 3.00 Y	15. 16. 17.
00	Did total beds available change from the prior PS&R Data 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) 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	Description	Pa Y/N 1.00 Y	Date 2.00	Part B Y/N 3.00 Y	16.
00	Did total beds available change from the price PS&R Data 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) 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) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional	Description	Pa Y/N 1.00 Y N	Date 2.00	Part B Y/N 3.00 Y	16.
00	Did total beds available change from the prior PS&R Data 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) 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) 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	Description	Pa Y/N 1.00 Y N	Date 2.00	Part B Y/N 3.00 Y	16.
00	Did total beds available change from the price PS&R Data 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) 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) 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.	Description	Pa Y/N 1.00 Y N N	Date 2.00	Part B Y/N 3.00 Y N	16. 17. 18.
00	Did total beds available change from the prior PS&R Data 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) 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) 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, were adjustments. If line 16 or 17 is yes, were adjustments.	Description	Pa Y/N 1.00 Y N	Date 2.00	Part B Y/N 3.00 Y	16. 17. 18.
00	Did total beds available change from the price PS&R Data 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) 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) 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. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of	Description	Pa Y/N 1.00 Y N N	Date 2.00	Part B Y/N 3.00 Y N	16. 17. 18.
00	Did total beds available change from the price PS&R Data 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) 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) 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. 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.	Description	Pa Y/N 1.00 Y N N	Date 2.00	Part B Y/N 3.00 Y N N	16. 17. 18. 19.
00	Did total beds available change from the price PS&R Data 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) 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) 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. 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	Description	Pa Y/N 1.00 Y N N	Date 2.00	Part B Y/N 3.00 Y N	16.

Heal th	Financial Systems	MAJOR HO	OSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		Period:	Worksheet S-2	2
					rom 01/01/2015 o 12/31/2015	Part II Date/Time Pre	epared:
						4/28/2016 3:2	20 pm
		Docor	intion		Tt A	Part B Y/N	
			iption 0	Y/N 1.00	Date 2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		<u>.</u>	N	2.00	N	21.00
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT Capital Related Cost	TALS ONLY (EXCE	EPT CHILDRENS H	IOSPI TALS)			-
22.00	Have assets been relifed for Medicare purpose	es? If ves. see	e instructions			N	22.00
23.00	Have changes occurred in the Medicare depreci			als made durin	g the cost	N	23.00
	reporting period? If yes, see instructions.				0		
24.00	Were new leases and/or amendments to existing If yes, see instructions	g leases enter	ed into during	this cost repo	rting period?	N	24.00
25.00	Have there been new capitalized leases entere instructions.	Ũ		0.1	5	Ν	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquinstructions.	uired during tl	he cost reporti	ng period? If	yes, see	N	26.00
27.00	Has the provider's capitalization policy char copy.	nged during the	e cost reportin	ng period? If y	es, submit	Ν	27.00
	Interest Expense	<u> </u>		·		N/	
28.00	Were new loans, mortgage agreements or letter period? If yes, see instructions.	rs of credit ei	ntered into dur	ring the cost r	eporting	Y	28.00
29.00	Did the provider have a funded depreciation a treated as a funded depreciation account? If	account and/or	bond funds (De	ebt Service Res	erve Fund)	Ν	29.00
30.00	Has existing debt been replaced prior to its			debt? If yes,	see	Ν	30.00
31.00	instructions. Has debt been recalled before scheduled matur	rity without i	ssuance of new	debt? If ves	see	N	31.00
01100	Purchased Services						
32.00	Have changes or new agreements occurred in pa	atient care se	rvi ces furni she	d through cont	ractual	N	32.00
	arrangements with suppliers of services? If y If line 32 is yes, were the requirements of S	yes, see instru	uctions.	0		N	33.00
00.00	no, see instructions.	2100.2 up		ig to competi ti	ve bruuring. Ti		00.00
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facili If yes, see instructions.	ity under an a	rrangement with	n provi der-base	d physi ci ans?	Y	34.00
35.00	If line 34 is yes, were there new agreements physicians during the cost reporting period?		0 0	nts with the pr	ovi der-based	Ν	35.00
					Y/N	Date	
					1.00	2.00	
36.00	Home Office Costs Were home office costs claimed on the cost re	enort?			N		36.00
	If line 36 is yes, has a home office cost sta If yes, see instructions.		repared by the	home office?	N		37.00
38.00	If line 36 is yes, was the fiscal year end of the provider? If yes, enter in column 2 the 1				N		38.00
39.00	If line 36 is yes, did the provider render se see instructions.				N		39.00
40.00	If line 36 is yes, did the provider render se instructions.	ervices to the	home office?	lf yes, see	N		40.00
			1.	00	2.	00	
	Cost Report Preparer Contact Information		100 5				
41.00	Enter the first name, last name and the title held by the cost report preparer in columns		KYLE		SMI TH		41.00
42.00	respectively. Enter the employer/company name of the cost r	report	BLUE & CO				42.00
40	preparer.	6 H					
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv		317-713-7957		KCSMI TH@BLUEANI	DCO. COM	43.00

Heal th	Financial Systems	MAJOR HOS	5PI TAL		In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Pre 4/28/2016 3:2	pared:
		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		5.	00			
	Enter the first name, last name and the title held by the cost report preparer in columns respectively.		ENI OR MANAGER	2			41.00
42.00	Enter the employer/company name of the cost	report					42.00
43.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv						43.00

	Financial Systems	MAJOR HO	SPI TA				eu of Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA		Provi der	CCN: 150097	Period: From 01/01/2015 To 12/31/2015		pared:
							I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Available	CAH Hours	Title V	
	1	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, 98	0.00	0	1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider							2.00 3.00
4.00	HMO I RF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			52	18, 98	0.00	0	6.00 7.00
8.00	beds) (see instructions) INTENSIVE CARE UNIT	31.00		9				8.00
9.00	CORONARY CARE UNIT	01.00		,	0,20	0.00	0	9,00
10.00	BURN I NTENSI VE CARE UNI T							10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14.00	Total (see instructions)			61	22, 26	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	SUBPROVI DER	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	
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	
29.00 30.00	Ambul ance Trips							29.00
30.00	Employee discount days (see instruction) Employee discount days - IRF							30.00 31.00
31.00				0		0		31.00
32.00 32.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room			0		U		32.00
32.01	outpatient days (see instructions)							32.01
33.00	LTCH non-covered days							33.00

HOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 150097		riod: om 01/01/2015 12/31/2015	Worksheet S-3 Part I Date/Time Pre 4/28/2016 3:2	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients		Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4, 445	438	9, 33	36			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, 33	36			7.00
8.00	INTENSIVE CARE UNIT	560	0	1, 08	86			8.00
9.00	CORONARY CARE UNI T							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14.00	Total (see instructions)	5,005	438	10, 42	22	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	
18.00	SUBPROVI DER	0	0		0	0.00	0.00	
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE	0 550		10 (0		0.00	40.44	21.00
22.00	HOME HEALTH AGENCY	8, 552	269	10, 60	JI	0.00	12.46	
23.00 24.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE							23.00 24.00
24.00	HOSPICE HOSPICE (non-distinct part)	o	0		0			24.00
24.10	CMHC - CMHC	0	0		0			24.10
26.00	RURAL HEALTH CLINIC	0	0		0	0.00	0.00	
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00	0.00	
27.00	Total (sum of lines 14-26)	Ŭ	0		Ŭ	0.00	615.58	
28.00	Observation Bed Days		268	1, 04	44	0.00	010.00	28.00
29.00	Ambul ance Trips	0	200	.,				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	e	60			32.00
32.01	Total ancillary labor & delivery room				0			32.01
	outpatient days (see instructions)							
33.00	LTCH non-covered days	0						33.00

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part I Date/Time Prep 4/28/2016 3:20	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
. 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, 2	17 108	2, 722	1.0
2.00	HMO and other (see instructions)			20	68 450		2.0
8.00	HMO IPF Subprovider				0		3.0
l. 00	HMO IRF Subprovider				0		4.0
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
o. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
3.00	INTENSIVE CARE UNIT						8.0
9.00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY					0.700	13.0
4.00	Total (see instructions)	0.00	0	1, 2	17 108	2, 722	14.0
5.00	CAH visits						15.0
6.00	SUBPROVIDER - IPF	0.00					16.0
7.00	SUBPROVIDER - IRF	0.00	0		0 0	0	17.0
8.00	SUBPROVI DER	0.00	0		0 0	0	18.0
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE	0.00					21.0
2.00	HOME HEALTH AGENCY	0. 00					22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						23.0
4.00							24. 0 24. 1
4.10	HOSPICE (non-distinct part)						
5.00	CMHC - CMHC	0.00					25.0
6.00 6.25	RURAL HEALTH CLINIC	0.00					26.0 26.2
	FEDERALLY QUALIFIED HEALTH CENTER	0. 00 0. 00					
7.00	Total (sum of lines 14-26)	0.00					27.0
8.00	Observation Bed Days						28.0
9.00	Ambul ance Trips						29.0
0.00	Employee discount days (see instruction)						30.0
1.00	Employee discount days - IRF						31.0
2.00	Labor & delivery days (see instructions)						32.0
32. 01	Total ancillary labor & delivery room						32. C
	outpatient days (see instructions)						

PI T	Financial Systems AL WAGE INDEX INFORMATION			Provi der	F	Period: From 01/01/2015 To 12/31/2015		pared
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	(col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
0	Total salaries (see	200. 00	39, 635, 045	0	39, 635, 045	1, 265, 622. 00	31. 32	1.
	instructions)		~			0.00	0.00	
0	Non-physician anesthetist Part		Ĺ	0	C	0.00	0.00	2.
0	Non-physician anesthetist Part		C	0	C	0.00	0.00	3.
0	B Physician-Part A -		419, 527	0	419, 527	2, 316. 00	181. 14	4.
	Admi ni strati ve		417, 327		417, 327	2, 510.00	101.14	
1	Physicians - Part A - Teaching		0	0	0	0.00		
0	Physician-Part B Non-physician-Part B		3, 306, 300		3, 306, 300	9, 433. 00 0. 00		
0	Interns & residents (in an	21.00	C	0		0.00		
	approved program)			_				_
1	Contracted interns and residents (in an approved programs)		C	0		0.00	0. 00	7.
0	Home office personnel		C	0	C	0.00	0.00	8.
0	SNF	44.00	0	0	0	0.00		
00	Excluded area salaries (see instructions)		3, 461, 646	212, 576	3, 674, 222	81, 970. 00	44.82	10.
	OTHER WAGES & RELATED COSTS			1	1			
00	Contract Labor: Direct Patient Care		173, 158	0	173, 158	4, 673. 00	37.05	11.
00	Contract Labor: Top Level		C	0	C	0.00	0.00	12.
	management and other management and administrative services							
00	Contract Labor: Physician-Part		889, 609	0	889, 609	5, 394. 00	164. 93	13.
~ ~	A - Administrative							
00	Home office salaries & wage-related costs		C		C	0.00	0.00	14.
00	Home office: Physician Part A		C	0	C	0. 00	0.00	15.
00	- Administrative Home office and Contract				C	0.00	0.00	1/
00	Physicians Part A - Teaching		Ĺ	0		0.00	0.00	10.
	WAGE-RELATED COSTS			l			I	
00	Wage-related costs (core) (see instructions)		8, 526, 826	0	8, 526, 826			17
00	Wage-related costs (other)		C	0	C)		18
~~	(see instructions)		705 454		705 454			10
	Excluded areas Non-physician anesthetist Part		735,456 C		735, 456			19. 20.
	A							
00	Non-physician anesthetist Part		C	0	C)		21
00	Physician Part A -		17, 851	0	17, 851			22.
	Admi ni strati ve							
	Physician Part A - Teaching Physician Part B		C 474, 001		474, 001			22.
	Wage-related costs (RHC/FQHC)		474,001	0	474,001 C			24.
00	Interns & residents (in an		C	0	C)		25.
	approved program) OVERHEAD COSTS - DIRECT SALARIE	'S						
	Employee Benefits Department	4.00	504, 997	0	504, 997	10, 892. 00	46. 36	26.
	Administrative & General	5.00	7, 258, 436					
00	Administrative & General under contract (see inst.)		663, 363	0	663, 363	3, 988. 00	166. 34	28.
00	Maintenance & Repairs	6.00	C	0	C	0.00	0.00	29.
	Operation of Plant	7.00	802, 128		802, 128			
	Laundry & Linen Service Housekeeping	8.00 9.00	31, 318 767, 797		31, 318 767, 797			
	Housekeeping under contract		170, 185		170, 185			
00	(see instructions)	10.00	EE0 040	202 444	1/0 /00	11 000 00	14.00	24
	Dietary Dietary under contract (see	10.00	552, 810 214, 392		169, 699 214, 392			
	instructions)		211, 372					
	Cafeteria	11.00	C	383, 111	383, 111			
	Maintenance of Personnel Nursing Administration	12.00 13.00	C 1, 098, 634		0 1, 098, 634	0.00 30,051.00		
	Central Services and Supply	14.00	176, 415			0.00	0.00	
	Pharmacy	15.00	854, 099			22, 952. 00		

Health Financial Systems		MAJOR HO	SPI TAL		In Lieu of Form CMS-2552-10			
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3		
					rom 01/01/2015			
					To 12/31/2015	Date/Time Pre 4/28/2016 3:20		
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly		
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
			(from	(col.2 ± col.	Salaries in	col. 5)		
			Worksheet A-6)	3)	col. 4			
	1.00	2.00	3.00	4.00	5.00	6.00		
41.00 Medical Records & Medical	16.00	807, 955	0	807, 955	35, 493. 00	22. 76	41.00	
Records Library								
42.00 Social Service	17.00	C	0	(0.00	0.00	42.00	
43.00 Other General Service	18.00	C	0	(0.00	0.00	43.00	

Heal th	Financial Systems		MAJOR HO	SPI TAL		In Lieu of Form CMS-2552-10			
HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Period:	Worksheet S-3		
						From 01/01/2015 To 12/31/2015		arad	
						10 12/31/2013	4/28/2016 3:20		
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly		
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
				(from	(col.2 ± col.	Salaries in	col. 5)		
				Worksheet A-6)	3)	col. 4			
		1.00	2.00	3.00	4.00	5.00	6.00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY							
1.00	Net salaries (see		37, 376, 685	0	37, 376, 68	5 1, 268, 346. 00	29.47	1.00	
	instructions)								
2.00	Excluded area salaries (see		3, 461, 646	212, 576	3, 674, 22	2 81, 970. 00	44.82	2.00	
	instructions)								
3.00	Subtotal salaries (line 1		33, 915, 039	-212, 576	33, 702, 46	3 1, 186, 376. 00	28. 41	3.00	
	minus line 2)								
4.00	Subtotal other wages & related		1, 062, 767	0	1, 062, 76	7 10, 067. 00	105. 57	4.00	
	costs (see inst.)								
5.00	Subtotal wage-related costs		8, 544, 677	0	8, 544, 67	7 0.00	25.35	5.00	
	(see inst.)								
6.00	Total (sum of lines 3 thru 5)		43, 522, 483	-212, 576	43, 309, 90	7 1, 196, 443. 00	36. 20	6.00	
7.00	Total overhead cost (see		13, 902, 529	-388, 991	13, 513, 53	8 475, 737. 00	28. 41	7.00	
	instructions)								

Heal th	Financial Systems	MAJOR HOSPITA	1L		In Lie	u of Form CMS-2	2552-10
	AL WAGE RELATED COSTS		Provider CC	N: 150097	Period: From 01/01/2015 To 12/31/2015		pared:
						Amount	
						Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						1
	RETI REMENT COST						1
1.00	401K Employer Contributions					0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribut					0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see in					1, 906, 150	3.00
4.00	Qualified Defined Benefit Plan Cost (see instr					0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Or	gani zati on)					
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 F	ees				0	7.00
	HEALTH AND INSURANCE COST						
8.00	Health Insurance (Purchased or Self Funded)					4, 665, 613	
9.00	Prescription Drug Plan					29, 603	
10.00	Dental, Hearing and Vision Plan					40, 435	
11.00	Life Insurance (If employee is owner or benefi					57, 235	
12.00	Accident Insurance (If employee is owner or be					0	
13.00	Disability Insurance (If employee is owner or					133, 014	
14.00	Long-Term Care Insurance (If employee is owner	or beneficiary)				0	
15.00	'Workers' Compensation Insurance					186, 775	
16.00	Retirement Health Care Cost (Only current year	r, not the extraord	dinary accru	al require	ed by FASB 106.	0	16.00
	Non cumulative portion) TAXES						
17.00	FICA-Employers Portion Only					2, 639, 617	17.00
17.00	Medicare Taxes - Employers Portion Only					2,039,017	
18.00	Unemployment Insurance					57, 135	
	State or Federal Unemployment Taxes					0	
20.00	OTHER					0	20.00
21.00	Executive Deferred Compensation (Other Than Re	tirement Cost Rend	orted on lin	es 1 throu	inh 4 above (see	0	21.00
21.00	instructions))	the cost hope				Ū	21.00
22.00	Day Care Cost and Allowances					0	22.00
23.00	Tuition Reimbursement					38, 557	
24.00	Total Wage Related cost (Sum of lines 1 -23)					9, 754, 134	24.00
	Part B - Other than Core Related Cost						1
25.00	OTHER					31, 948	25.00

Heal th	Financial Systems	MAJOR HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	TAL CONTRACT LABOR AND BENEFIT COST	Provi de	er CCN: 150097	Peri od:	Worksheet S-3	
				From 01/01/2015 To 12/31/2015		norod.
				10 12/31/2015	Date/Time Pre 4/28/2016 3:2	
	Cost Center Description			Contract Labor		
				1.00	2.00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Identificat	i on:				
1.00	Total facility's contract labor and benefit cost			0	0	1.00
2.00	Hospi tal			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	Hospi tal -Based Hospi ce					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

Heal th	Financial Systems	MAJOR HC	SPI TAL		In Lie	eu of Form CMS-	2552-10
HOME H	IEALTH AGENCY STATI STI CAL DATA			CCN: 150097 t CCN: 157418	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
					Home Health Agency I	4/28/2016 3: 2 PPS	<u>0 pm</u>
						00	-
0.00	County				I.	00	0.00
0100	loounty	Title V	Title XVIII	Title XIX	Other	Total	0.00
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA	-	-	.1		-	
1.00	Home Heal th Ai de Hours	0.00			0 0 00 0.00		
2.00	Unduplicated Census Count (see instructions)	0.00	324.00		ployees (Full Ti		2.00
		Enter the numb	er of hours in	Staff	Contract	Total	
			l work week	- Otari		Total	
		(0	1.00	2.00	3.00	
3.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)	1	0.00	0.0	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.0			•
5.00	Other Administrative Personnel			0.0			•
6.00	Direct Nursing Service			0.0			•
7.00 8.00	Nursing Supervisor Physical Therapy Service			0.0			
9.00	Physical Therapy Supervisor			0.0			
10.00	Occupational Therapy Service			0.0			•
11.00	Occupational Therapy Supervisor			0.0	0.00	0.00	11.00
12.00	Speech Pathology Service			0.0			•
13.00	Speech Pathol ogy Supervi sor			0.0			•
14.00 15.00	Medical Social Service Medical Social Service Supervisor			0.0			•
16.00	Home Health Aide			0.0			•
17.00	Home Health Aide Supervisor			0. (
18.00	Other (specify)			0.0	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES	1		1	-1	1	
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost				2		19.00
	reporting period.						
20.00	List those CBSA code(s) in column 1 serviced			26900			20.00
	during this cost reporting period (line 20						
20. 01	contains the first code).			50032			20.01
20.01		Full E	pi sodes	50032			20.01
			With Outliers	LUPA Epi sode	2	Total (cols.	
		Outliers	2.00	2.00	Epi sodes	1-4)	
	PPS ACTIVITY DATA	1.00	2.00	3.00	4.00	5.00	
21.00	Skilled Nursing Visits	3, 578	644	l !	56 17	4, 295	21.00
22.00	Skilled Nursing Visit Charges	794, 316		1			
23.00	Physical Therapy Visits	2, 105			13 16 12 2 276		
24.00 25.00	Physical Therapy Visit Charges Occupational Therapy Visits	444, 155			43 3, 376 1 0	489, 309	
26.00	Occupational Therapy Visits Occupational Therapy Visit Charges	103, 026			23 0	121, 981	
27.00	Speech Pathology Visits	13	4	L .	0 0	17	27.00
28.00	Speech Pathology Visit Charges	2, 951		3	0 0	3, 859	
29.00 30.00	Medical Social Service Visits Medical Social Service Visit Charges	39			1 0 08 0	49 15, 092	•
30.00	Home Health Aide Visits	12, 012			5 0	1, 325	
32.00	Home Health Aide Visit Charges	104, 048			50 0	148, 400	
33.00	Total visits (sum of lines 21, 23, 25, 27,	7, 126			76 33		
04.05	29, and 31)	-	-		-	_	
34.00 35.00	Other Charges Total Charges (sum of Lipos 22, 24, 26, 28	1 460 509			0 0	-	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1, 460, 508	248, 207	16, 20	56 7, 150	1, 732, 131	35.00
36.00	Total Number of Episodes (standard/non	362		:	26 3	391	36.00
37.00	outlier) Total Number of Outlier Episodes		26		0	26	37.00
38.00	Total Non-Routi ne Medical Supply Charges	226			0 0		38.00

Heal th	Financial Systems MAJOR HOSPITA	AL		In Li€	eu of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150097	Peri od:	Worksheet S-1	0
				From 01/01/2015 To 12/31/2015		narad
				10 12/31/2013	4/28/2016 3:2	o pm
					1.00	
	Uncompensated and indigent care cost computation					
	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by lin	ne 202 columr	ו 8)	0. 267850	1.00
	Medicaid (see instructions for each line) Net revenue from Medicaid				3, 949, 019	2.00
2.00 3.00	Did you receive DSH or supplemental payments from Medicaid?				3, 949, 019 Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental	navments	From Medicai	12	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from			A .	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 minu	us sum of lir	nes 2 and 5; if	0	8.00
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instruct	ions for ea	ach line)		1	
	Net revenue from stand-al one SCHIP				0	9.00
	Stand-alone SCHIP charges				0	10.00
	Stand-alone SCHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone SCHIP	(lino 11 mi	nus lino 0	if < zoro thon	0	11.00 12.00
12.00	enter zero)		nus inte 7,		0	12.00
	Other state or local government indigent care program (see inst	ructions fo	or each line)	1		
	Net revenue from state or local indigent care program (Not incl				0	13.00
14.00	Charges for patients covered under state or local indigent care	program (I	Not included	in lines 6 or	0	14.00
	10)					
	State or local indigent care program cost (line 1 times line 14	·	<i>.</i>		0	15.00
16.00	Difference between net revenue and costs for state or local ind	igent care	program (lir	ne 15 minus line	0	16.00
	13; if < zero then enter zero) Uncompensated care (see instructions for each line)					
	Private grants, donations, or endowment income restricted to fu	nding chari	ty care		0	17.00
	Government grants, appropriations or transfers for support of h				0	18.00
	Total unreimbursed cost for Medicaid , SCHIP and state and loca			ns (sum of lines	0	19.00
	8, 12 and 16)			-		
			Uni nsured	Insured	Total (col. 1	
		-	patients 1.00	patients 2.00	+ col. 2) 3.00	
20.00	Total initial obligation of patients approved for charity care	(at full	5, 409, 8			20.00
20.00	charges excluding non-reimbursable cost centers) for the entire		5, 409, 8	57	5,409,057	20.00
21.00	Cost of initial obligation of patients approved for charity car		1, 449, 03	30 0	1, 449, 030	21.00
	times line 20)					
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, 03	30 0	1, 449, 030	23.00
0.1.00				<u> </u>	1.00	04.00
24.00	Does the amount in line 20 column 2 include charges for patient imposed on patients covered by Medicaid or other indigent care		nd a length d	or stay limit	N	24.00
25 00	If line 24 is "yes," charges for patient days beyond an indige		ogram's lengt	th of stav limit	0	25.00
	Total bad debt expense for the entire hospital complex (see ins		- <u>-</u>	of oray frint	7, 424, 942	
	Medicare bad debts for the entire hospital complex (see instruc				207, 444	
	Non-Medicare and non-reimbursable Medicare bad debt expense (li	,	s line 27)		7, 217, 498	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (line	1 times line	e 28)	1, 933, 207	
	Cost of uncompensated care (line 23 column 3 plus line 29)				3, 382, 237	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			3, 382, 237	31.00

CLASS	Financial Systems IFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	MAJOR HOSI F EXPENSES			Period:	u of Form CMS-2 Worksheet A	2002 1
					From 01/01/2015 To 12/31/2015	Date/Time Pre 4/28/2016 3:2	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
(GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
	DO100 CAP REL COSTS-BLDG & FIXT		2, 848, 702	2, 848, 70	2 0	2, 848, 702	1.00
00 0	00300 OTHER CAPITAL RELATED COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	504, 997	0 7, 252, 940	7, 757, 93		0 7, 757, 937	3.00 4.00
	01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG	0 1, 162, 508	0 2, 580, 023	3, 742, 53	0 15,000 1 0	15, 000 3, 742, 531	5.01 5.02
	DO590 PURCHASING, RECEIVING, AND STORES	226, 025	111, 875	337, 90		337, 900	5.03
	DO570 ADMI TTI NG	974, 924	107, 236			1, 067, 160	
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	541, 536	1,068,156			1, 609, 692	5.0
	00592 OTHER ADMINISTRATIVE AND GENERAL	4, 353, 443 802, 128	4, 291, 308 1, 338, 903			8, 278, 713 2, 141, 031	5.00 7.00
	DOBOO LAUNDRY & LINEN SERVICE	31, 318	1, 338, 903			2, 141, 031 216, 528	
	DO900 HOUSEKEEPING	767, 797	435, 001	1, 202, 79		1, 202, 798	
	D1000 DI ETARY	552, 810	912, 208	1, 465, 01		449, 724	10.00
	D1100 CAFETERI A	0	0		0 1, 015, 294	1, 015, 294	
	01300 NURSI NG ADMI NI STRATI ON	1,098,634	242, 920			1, 341, 554	13.00
	01400 CENTRAL SERVICES & SUPPLY	176, 415	258, 750			0	14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	854, 099 807, 955	5, 409, 407 324, 431			6, 263, 506 1, 132, 386	
	NPATIENT ROUTINE SERVICE COST CENTERS	007, 733	524, 451	1, 132, 30	0	1, 132, 300	10.00
	D3000 ADULTS & PEDI ATRI CS	5, 452, 174	1, 209, 449	6, 661, 62	3 25, 308	6, 686, 931	30.00
	D3100 INTENSIVE CARE UNIT	1, 075, 094	350, 049	1, 425, 14	3 0	1, 425, 143	31.00
	04100 SUBPROVIDER – IRF	0	0	(0	0	41.00
	04200 SUBPROVI DER	0	0		0 0	0	42.00
	ANCI LLARY SERVI CE COST CENTERS	2, 900, 193	1, 464, 913	4, 365, 10	6 176, 429	4, 541, 535	50.00
	D5200 DELIVERY ROOM & LABOR ROOM	2, 700, 173	1, 404, 713	4, 303, 10		4, 541, 555	52.00
	D5300 ANESTHESI OLOGY	2, 483, 890	359, 801	2, 843, 69	1 0	2, 843, 691	53.00
. 00	D5400 RADI OLOGY-DI AGNOSTI C	2, 096, 882	2, 843, 916	4, 940, 79	в О	4, 940, 798	54.00
	D5600 RADI OI SOTOPE	0	0		0 0	0	56.00
	D5601 ONCOLOGY	1, 120, 687	864, 683			1, 985, 370	
	D5700 CT_SCAN D5800 MAGNETIC_RESONANCE_IMAGING_(MRI)	316, 411 310, 063	507, 038 394, 094			823, 449 704, 157	57.00 58.00
	05900 CARDI AC CATHETERI ZATI ON	310,003	394, 094 0	704,15	0 0	704, 137	59.00
	D6000 LABORATORY	1, 832, 889	2, 765, 897	4, 598, 78	-	4, 598, 786	
. 01	D6001 BLOOD LABORATORY	0	0	(0 0	0	60. 0 ⁻
	D6500 RESPI RATORY THERAPY	802, 768	194, 636			997, 404	65.00
	06501 SLEEP LAB	402,031	199, 777	601, 80		601, 808	
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	1, 441, 915 478, 678	598, 281 174, 714	2, 040, 19 653, 39		2, 040, 196 653, 392	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	91, 693	3, 030, 357			1, 634, 627	
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0,000,007		1, 487, 423		
	07300 DRUGS CHARGED TO PATIENTS	0	0	(0 0	0	
	DUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0		0 0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	230, 291	113, 894	344, 18	5 0	0 344, 185	89.00 90.00
	D9100 EMERGENCY	2, 283, 151	1, 617, 110			4, 133, 689	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		., ,	-,,		.,,	92.00
	OTHER REIMBURSABLE COST CENTERS						
	D9500 AMBULANCE SERVI CES	0	0	(0 0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	
	10000 I &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	771, 118	0 540, 981	1, 312, 09		0 1, 312, 099	100.00
	SPECIAL PURPOSE COST CENTERS	771,110	540, 901	1, 312, 04	9 0	1, 312, 077	
	11300 I NTEREST EXPENSE		0		0 0	0	113.00
8.00	SUBTOTALS (SUM OF LINES 1-117)	36, 944, 517	44, 596, 660	81, 541, 17	7 - 366, 038	81, 175, 139	118.00
	VONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19001 SHELBY COUNTY MEDICAL CENTER 19002 SICK CHILD CARE	0	0				190. 0′ 190. 02
	19002 PRI VATE DUTY	0	0				190. 0
	19004 ST. VINCENT'S STRESS	0	0		0 0		190. 04
	19005 MARKETI NG	0	0		366, 038	366, 038	
	19006 MH LI GHTBOUND	0	0		0 0		190. 0
	19007 I -74 CAMPUS	148, 069	506, 986	655, 05	5 0	655, 055	
	19008 SOUTHEAST OB	0	0	(0 0		190.0
	19009 INTELLIPLEX DEVELOPMENT	12, 412	79, 241	91, 65	3 0	91, 653	
	19010 MS&M 19011 OTHER NON-REIMBURSEABLE CENTERS	0	0				190. 1 190. 1
0 11	LAVE FROM THE NUMBER FLUIDUR SEADLE VENTERS	0	0	1 (J U	0	
	19012 BARTLEY ORTHOPEDICS		0			0	190.1

Health Financial Systems	MAJOR HOS	SPI TAL		In Lieu of Form CMS-2552-10			
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der		Period: From 01/01/2015	Worksheet A		
				To 12/31/2015		pared: 0 pm	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed		
			+ col. 2)	ons (See A-6)	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	3 0	47, 853	190. 16	
190. 17 19017 I MA	0	0	(0 0	0	190. 17	
190. 18 19018 MD SOLUTI ONS	0	0	(0 0	0	190. 18	
190. 19 19019 MHCD	0	1, 296, 750	1, 296, 750	0 0	1, 296, 750	190. 19	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	(0 0	0	192.00	
192. 01 19201 HOSPI TALI ST	1, 870, 567	216, 136	2, 086, 703	3 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	3 0	86, 557, 748	200. 00	

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	I EXI ENSES	Provi der	0011. 1000	From 01/01/201		
		1 1			To 12/31/201	15 Date/Time Prepa 4/28/2016 3:20	
	Cost Center Description	Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	-			
	GENERAL SERVICE COST CENTERS			1			
00	00100 CAP REL COSTS-BLDG & FIXT	-293, 056	2, 555, 646	1			1.
00 00	00300 OTHER CAPITAL RELATED COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	2 407	7 754 520	1			3. 4.
00	01160 COMMUNI CATI ONS	-3, 407 -3, 037	7, 754, 530 11, 963	1			4. 5.
02	00550 DATA PROCESSI NG	-290, 120	3, 452, 411	1			5.
03	00590 PURCHASING, RECEIVING, AND STORES	0	337, 900	1			5.
04	00570 ADMI TTI NG	-6, 731	1, 060, 429				5.
05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-56, 796	1, 552, 896	1			5
)6	00592 OTHER ADMINISTRATIVE AND GENERAL	-1, 450, 096	6, 828, 617	1			5
)0)0	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	2, 141, 031 216, 528	1			7 8
00	00900 HOUSEKEEPING	-530	1, 202, 268	1			9
	01000 DI ETARY	-224, 508	225, 216	1			10
	01100 CAFETERI A	-601, 711	413, 583	1			11
00	01300 NURSING ADMINISTRATION	-129, 143	1, 212, 411			1	13
	01400 CENTRAL SERVI CES & SUPPLY	0	(1			14
	01500 PHARMACY	-146, 424	6, 117, 082	1			15
00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	-29, 050	1, 103, 336				16
00	03000 ADULTS & PEDIATRICS	-275, 773	6, 411, 158				30
	03100 I NTENSI VE CARE UNI T	-29, 371	1, 395, 772	1			31
	04100 SUBPROVI DER – I RF	0	(1			41
00	04200 SUBPROVI DER	0	(4	42
	ANCI LLARY SERVICE COST CENTERS			1			
	05000 OPERATING ROOM	-569, 489	3, 972, 046	1			50
	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0 -1, 970, 539	(873, 152	1			52 53
	05400 RADI OLOGY – DI AGNOSTI C	-1, 037, 004	3, 903, 794	1			53 54
	05600 RADI OL SOTOPE	0	3, 703, 77	1			56
	05601 ONCOLOGY	-201,019	1, 784, 351				56
00	05700 CT SCAN	-106, 126	717, 323			5	57
	05800 MAGNETIC RESONANCE IMAGING (MRI)	-50, 012	654, 145				58
	05900 CARDI AC CATHETERI ZATI ON	0	(1			59
00 01	06000 LABORATORY 06001 BLOOD LABORATORY	-253, 112	4, 345, 674				60 60
00	06500 RESPIRATORY THERAPY	-24, 661	972, 743				65
	06501 SLEEP LAB	-18, 627	583, 181	1			65
	06600 PHYSI CAL THERAPY	-118, 268	1, 921, 928	1		6	66
	06900 ELECTROCARDI OLOGY	-84, 374	569, 018			6	69
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	-125, 752	1, 508, 875				71
00	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	0	1, 487, 423				72
00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	('	73
	08800 RURAL HEALTH CLINIC	0	(88
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(89
00	09000 CLINIC	-303, 169	41, 016			ç	90
	09100 EMERGENCY	-881, 170	3, 252, 519				91
00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)					¢	92
00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES			1			95
	09300 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP-SOLD	0	(90
	10000 I &R SERVICES-NOT APPRVD PRGM	0	(100
	10100 HOME HEALTH AGENCY	-478	1, 311, 621				01
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	0	(1			113
3. 00		-9, 283, 553	71, 891, 586			11	18
	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	(11	90
	19001 SHELBY COUNTY MEDICAL CENTER	0	(1			190
	19002 SICK CHILD CARE	0	(90
	19003 PRI VATE DUTY	0	(90
0. 04	19004 ST. VINCENT'S STRESS	0	(90
	19005 MARKETI NG	0	366, 038				90
	19006 MH LI GHTBOUND	0	(90
	19007 I -74 CAMPUS	0	655, 055				90
	19008 SOUTHEAST OB 19009 INTELLIPLEX DEVELOPMENT	0	91, 653				90 90
	19009 INTELLIPLEX DEVELOPMENT	0	71, 003 (190 190
	19011 OTHER NON-REIMBURSEABLE CENTERS	0	(90
		0	(90
D. 12	19012 BARTLEY ORTHOPEDI CS						
D. 13	19012 BARTLEY ORTHOPEDICS 19013 SSA 19014 SPORTSWORKS	0	(19	90 90

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der	CCN: 150097	Period: From 01/01/2015	Worksheet A
				To 12/31/2015	Date/Time Prepared: 4/28/2016 3:20 pm
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For Allocation			
	6.00	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 PHYSI CLANS' PRI VATE OFFI CES	0	0			192.00
192. 01 19201 HOSPI TALI ST	-9, 229	2,077,474			192.01
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	-4,370	834, 187			194.00
200.00 TOTAL (SUM OF LINES 118-199)	-9, 316, 935	77, 240, 813			200. 00

Heal th	Financial Systems		MAJOR HO	SPI TAL		In Lieu of Form CMS-2552-10			
RECLAS	SIFICATIONS			Provi der	CCN: 150097	Period: Worksheet	A-6		
						From 01/01/2015 To 12/31/2015 Date/Time	Droparad		
						4/28/2016	3:20 pm		
		Increases							
	Cost Center	Line #	Sal ary	0ther					
	2.00	3.00	4.00	5.00					
	A – CAFETERIA								
1.00	CAFETERI A		38 <u>3, 1</u> 11	63 <u>2, 1</u> 83			1.00		
	0		383, 111	632, 183					
	B - COMMUNICATIONS								
1.00	COMMUNI CATI ONS	5.01	15,000	0			1.00		
	0		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		
	0		176, 415	258, 750					
	D – MARKETING								
1.00	MARKETING	<u> </u>	21 <u>2, 5</u> 76	15 <u>3, 4</u> 62			1.00		
	0		212, 576	153, 462					
	E – IMPLANTABLE DEVICES RECLASS								
1.00	IMPL. DEV. CHARGED TO	72.00	41, 392	1, 446, 031			1.00		
	PATI ENT								
	0		41, 392	1, 446, 031					
500.00	Grand Total: Increases		828, 494	2, 490, 426			500.00		

Heal th	Financial Systems		MAJOR HO	In Lieu of Form CMS-2552-10				
RECLAS	SEFECATIONS			Provi der	CCN: 150097	Peri od:	Worksheet A-	6
						From 01/01/2015 To 12/31/2015	Date/Time Pr 4/28/2016 3::	epared: 20 pm
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref			
	6. 00	7.00	8.00	9.00	10.00			
	A – CAFETERIA				1	-		1
1.00	<u>DIETARY</u>	<u> </u>	38 <u>3, 1</u> 11	63 <u>2, 1</u> 83	<u> </u>	이		1.00
	0		383, 111	632, 183				1
	B - COMMUNICATIONS				1	-1		
1.00	ADMI TTI NG	5.04	15,000		· · · · · · · · · · · · · · · · · · ·	Q		1.00
	O C – CS&R OTHER		15, 000	0				4
1.00	CENTRAL SERVICES & SUPPLY	14.00	176, 415	258, 750		0		1.00
2.00	CENTRAL SERVICES & SUPPLY	0.00	170, 415	256, 750				2.00
3.00		0.00	0	0				3.00
0.00	<u> </u>		176, 415	258, 750	<u> </u>	1		0.00
	D - MARKETING	I	1707110	200,700				1
1.00	OTHER ADMINI STRATI VE AND	5.06	212, 576	153, 462		0		1.00
	GENERAL							
	0		212, 576	153, 462				
	E - IMPLANTABLE DEVICES RECLA							
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	41, 392	1, 446, 031		0		1.00
	PATI ENTS				<u> </u>	_		
			41, 392	1, 446, 031		4		
500.00	Grand Total: Decreases		828, 494	2, 490, 426	4			500.00

Health Financial Systems	MAJOR HO	SPI TAL		In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150097	Peri od:	Worksheet A-7		
				From 01/01/201 To 12/31/201		nared	
				10 12/31/20	4/28/2016 3:2	0 pm	
			Acqui si ti on	s			
	Begi nni ng	Purchases	Donati on	Total	Disposals and		
	Bal ances	2.00	2.00	4.00	Retirements		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASS	1.00	2.00	3.00	4.00	5.00		
1.00 Land	1, 737, 322	241, 034		0 241,03	34 0	1.00	
2.00 Land Improvements	5, 939, 611			0 110, 17		2.00	
3.00 Buildings and Fixtures	35, 824, 543			0 53, 709, 6			
4.00 Building Improvements	3, 436, 943			0 315,66		•	
5.00 Fixed Equipment	1, 731, 959	73, 946		0 73, 94	937, 549	5.00	
6.00 Movable Equipment	33, 250, 141	2, 159, 568		0 2, 159, 56	4, 283, 727	6.00	
7.00 HIT designated Assets	0	, v		0	0 0		
8.00 Subtotal (sum of lines 1-7)	81, 920, 519	56, 610, 003		0 56, 610, 00			
9.00 Reconciling Items	0	0		0	0 0		
10.00 Total (line 8 minus line 9)	81, 920, 519			0 56, 610, 00	3 8, 141, 522	10.00	
	Endi ng Bal ance	Fully Depreciated					
		Assets					
	6,00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASS							
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					3.00	
4.00 Building Improvements	3, 737, 952					4.00	
5.00 Fixed Equipment	868, 356					5.00	
6.00 Movable Equipment	31, 125, 982	0				6.00	
7.00 HIT designated Assets	120, 200, 000	0				7.00	
8.00 Subtotal (sum of lines 1-7) 9.00 Reconciling Items	130, 389, 000					8.00 9.00	
10.00 Total (line 8 minus line 9)	130, 389, 000	-				9.00	
10.00 protai (inne o minus fille 7)	130, 309, 000	0	I			1 10.00	

Heal th	Financial Systems	MAJOR HO	ISPI TAL		In Lieu of Form CMS-2552-10			
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015	Worksheet A-7 Part II		
					To 12/31/2015			
			SL	JMMARY OF CAPI	TAL			
	Cost Center Description	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 WORK	RKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2, 550, 359	0	287, 83	7 0	0	1.00	
3.00	Total (sum of lines 1-2)	2, 550, 359	0	287, 83	7 0	0	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum	1				
		Capi tal -Rel ate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14.00	15.00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 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	

Health Financial Systems	MAJOR HO	SPI TAL		In Lieu of Form CMS-2552-		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015 To 12/31/2015		
	COMI	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col	instructions)	Insurance	
			2)	1.00		
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT	130, 389, 000	0	130, 389, 00	0 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	130, 389, 000		130, 389, 00			3.00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					01.00
Cost Center Description	Taxes	Other Capital-Relate d 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 CE	NTERS					
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
			JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate d Costs (see i nstructi ons)	of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	-		0 10, 506		1.00
3.00 Total (sum of lines 1-2)	0	0	l	0 10, 506	2, 555, 646	3.00

	Financial Systems MENTS TO EXPENSES		MAJOR HO	Provider CCN: 150097 Pe	<u>In Lie</u> eriod: rom 01/01/2015	u of Form CMS-2 Worksheet A-8	2552-10
				Te		Date/Time Prep 4/28/2016 3:20	
				Expense Classification on To/From Which the Amount is		1,20,2010 0.2	5 pm
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00		1.00	2.00	3.00	4.00	5.00	1 00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В		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	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter	А	-3, 037	COMMUNI CATI ONS	5. 01	0	7.00
8.00	21) Tel evi si on and radio service		0		0.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provi der-based physici an adjustment	A-8-2	-3, 886, 248		0.00	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		
14.00 15.00	Cafeteria-employees and guests Rental of quarters to employee		-321, 515 0	CAFETERI A	11.00 0.00	0	14. 00 15. 00
16.00	and others Sale of medical and surgical supplies to other than		O		0.00	0	16.00
17.00	patients Sale of drugs to other than		C		0.00	0	17.00
18.00	patients Sale of medical records and		0		0.00	0	18.00
19.00	abstracts Nursing school (tuition, fees,		0		0.00	0	19.00
	books, etc.)		0				
20. 00 21. 00	Vending machines Income from imposition of interest, finance or penalty		0		0.00 0.00	0	
22.00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	O	RESPI RATORY THERAPY	65.00		23. 00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 00
26.00	(chapter 21) Depreciation - CAP REL		C	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		C	*** Cost Center Deleted ***	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 30.00	Physicians' assistant Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	0.00 67.00	0	
30.00	therapy costs in excess of limitation (chapter 14)	H-0-2	U		67.00		50.00
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech	A-8-3	C	*** Cost Center Deleted ***	68.00		31.00
22.00	pathology costs in excess of limitation (chapter 14)		~		0.00		22.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00		
	FOOD AND NUTRITION DIABETIC ED	B B		DI ETARY NURSI NG ADMI NI STRATI ON	10. 00 13. 00		

From 01/2012 Description from the first of the Annual Lis to be Application for the Applicatio		Financial Systems		MAJOR HO			u of Form CMS-2	
Cost Center Description Basis/Code (2) Amount Cost Center Line # With A 26 00 Cost Center Description 1.00 2.00 4.00 4.00 5.00 26 00 Cost Center Revenues Revista 8 -2.200 1.00 0.00 6.00 6.00 6.00 0.00 5.00 0.00 <th>ADJUS I (</th> <th>NENTS IU EXPENSES</th> <th></th> <th></th> <th>Provi der CCN: 150097</th> <th>Period: From 01/01/2015 To 12/31/2015</th> <th>Worksheet A-8 Date/Time Pre</th> <th>pared:</th>	ADJUS I (NENTS IU EXPENSES			Provi der CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8 Date/Time Pre	pared:
Image: Constraint Deck 1.00 2.00 3.00 4.00 5.00 36.00 CAPETERIA - EMD A -28.01 (APA REL COSTS-BLD & FLXT 1.00 9 37.00 IMI OTHER REVEWES RETAL B -2.405 (APA REL COSTS-BLD & FLXT 1.00 9 37.00 IMI OTHER REVEWES CONTRACT A -2.90, 1200AA PROCESSING 5.02 0 38.00 IMI REGISTRATION CONTRACT LABOR A -6.734 (ADMI TINKS 5.06 0 39.00 IMI PT FLAWCE SUSSIONTACT A -6.67, 26 (ASH ERI NC/ACOUNTS 5.06 0 40.00 IMI PT FLAWCE SUSSIONTACT A -2.82, 270 (TER ADMI IN STATIV E AND 5.06 0 1.00 IMI ACOUNTING CONTRACT A -3.22, 270 (TER ADMI IN STATIV E AND 5.06 0 1.4000 IMI ACOUNTING CONTRACT A -3.23, 200 (TER ADMI IN STATIV E AND 5.06 0 1.4000 IMI ACOUNTING CONTRACT A -3.42, 400 (TER ADMI IN STATIV E AND 5.06 0 1.4000 IMI ACOUNTING CONTRACT A -3.42, 400 (MI NI STATIV E AND							472072010 3.2	
1 00 2:00 3:00 4:00 5:00 36.00 CAPETERIA - EMD A -2:00 3:00 4:00 5:00 36.00 WH OTHER REVENUES RUTAL B -2:00 10:00 9 37.00 WH OTHER REVENUES RUTAL B -2:00 12:00 5:00 0 37.00 WH ING SYSLUS CONTRACT A -2:00 12:00 5:00 0 38.00 WH REGISTRATION CONTRACT A -5:07 -5:00 0								
1.00 2.00 3.00 4.00 5.00 35.00 CAPETERIA - EMP A -28.0196/CAPETERIA - LOSIS-BLD & FLXT 1.00 9 37.00 IM. DIRR MUMIUS RENTAL LAGOR A -28.0196/CAPETERIA - LOSIS-BLD & FLXT 1.00 9 37.00 IM. DIRR MUMIUS RENTAL LAGOR A -20.0120 ATA PROCESSING 5.02 0 37.00 IM. PT FLAWLES CONTRACT LAGOR A -6.731 ADUIT TIME 5.06 0.0 37.00 IM. PT FLAWLES CONTRACT LAGOR A -6.731 ADUIT TIME 5.06 0.0 37.00 IM. PT FLAWLES CONTRACT LAGOR A -14.4 40.01 FIRM AND STRATUYE AND 5.06 0.0 42.00 IM. PEDLATION CLASS REVENUE B -13.512/DTER ADMINISTRATUYE AND 5.06 0.0 43.00 IM. ACCOUNTING CURRACT LABOR B -30.420/DTER ADMINISTRATUYE AND 5.06 0.0 1.4000 IM. ACCOUNTING VELODE REPATES B -30.420/DTER ADMINISTRATUYE AND 5.06 0.0 1.5000 IM. OTHER VELOWES B		Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
36. 00 INFORTER REFERENCES RENTAL B 2.451 CAP REL COSTS-RLIDG & FLXT 1.00 9 37. 00 INT INFO. SYSTEMS CONTRACT A 290, T20 (bit A PROCESSING 5.02 0 39. 00 INT INFO. SYSTEMS CONTRACT A 290, T20 (bit A PROCESSING 5.05 0 39. 00 INF PT FLANDOR CONTRACT A 2.473 (bit NT INFORCONTRIS 5.05 0 39. 00 INF PT FLANDOR CONTRACT A 2.473 (bit NT INFORCONTRIS 5.05 0 40. 00 INF ACCOUNTING CONTRACT A 2.82, 227 DTRER ADM INSTRATIVE AND 5.06 0 41. 00 INF EDUCATION CLASS REVENUE B 12.430 (bit READIN INSTRATIVE AND 5.06 0 42. 00 INF EDUCATION CLASS REVENUE B 2.444 (bit RE ADM IN STRATIVE AND 5.06 0 43. 00 IN MOSCULT INGK-FARM RENTAL B 3.12 (20) THER ADM IN STRATIVE AND 5.06 0 1ACOUNT ING VENDES PURCHASE B 2.24 (44) DITHE RAWIN INSTRATIVE AND 5.06 0 00 MIT OTHER REVENUES PURCHASE B	25 00	· · · · · · · · · · · · · · · · · · ·	1.00					25.00
LABOR CHARR CANDR A -6, 73 LADI TTI NC 5, 04 0 39, 00 M. HERLISTRATION CONTRACT A -56, 70 C/CASH ERING/ACCOUNTS 5, 05 0 40, 00 M. ACCOUNTING CONTRACT A -56, 70 C/CASH ERING/ACCOUNTS 5, 06 0 41, 00 MI ACCOUNTING CONTRACT A -144, 40 DEEREAL 5, 06 0 41, 00 MI ACCOUNTING CONTRACT A -322, 287 DTHE ADM IN STRATIVE AND 5, 06 0 43, 00 MI MCOULTING CONTRACT LABOR A -12, 512 DTHE ADM IN STRATIVE AND 5, 06 0 44, 00 MI MCOULTING VENDOR REBATES B -20, 444 DTHER ADM IN STRATIVE AND 5, 06 0 45, 00 MI ONDUTS VENDOR REBATES B -20, 444 DTHER ADM INSTRATIVE AND 5, 06 0 45, 00 MI ONTROL REPORT B -3, 00 DEEREAL NI STRATIVE AND 5, 06 0 45, 00 MI ONTROL REPORT B -20, 444 DTHER ADM INSTRATIVE AND 5, 06 0 45, 00 MI ONTROL REPORT B	36.00	MH OTHER REVENUES RENTAL						
39.00 MH PT FLANACE SUCS CONTRACT A -B6.796(ASH ERIKA/ACCOUNTS 5.05 O 40.00 MH ACCOUNTIN CONTRACT LABOR A -144.406(THER ADUIN STRATIVE AND 5.06 O 41.00 MI ADDRINI STRATION CONTRACT A -302.227(THER ADUIN STRATIVE AND 5.06 O 42.00 MI EDUCATION CLASS REVENUE B -12.512(DTHER ADUIN STRATIVE AND 5.06 O 43.00 MI ADSOLUTIONS-ADM RENTAL B -31.420(THER ADUIN STRATIVE AND 5.06 O 44.00 MI ACCOUNTING VENDOR REBATES B -2.244/410THER ADUIN STRATIVE AND 5.06 O 45.00 MI OTHER REVENUES PURCHASE B -4.0460/THER ADUIN STRATIVE AND 5.06 O 45.00 MI OTHER REVENUES B -4.0460/THER ADUIN STRATIVE AND 5.06 O 45.00 MI OTHER REVENUES B -4.0460/THER ADUIN STRATIVE AND 5.06 O 45.01 MI OTHER REVENUES B -2.050/FURCHAIN MI STRATIVE AND 5.06 O 45.02 MI OTHER REVENUES B -2.050/FURCHAIN ST		LABOR					0	
40.00 MH ACCOUNTING CONTRACT LABOR A -144.406/DTHER ADMINISTRATIVE AND 5.06 O 41.00 MH ADMINISTRATION CONTRACT A -382.287/DTHER ADMINISTRATIVE AND 5.06 O 42.00 MH ADMINISTRATION CONTRACT A -382.287/DTHER ADMINISTRATIVE AND 5.06 O 43.00 MH ADCOUNTING VENDOR REBATLS B -12.512/DTHER ADMINISTRATIVE AND 5.06 O 44.00 MI ACCOUNTING VENDOR REBATLS B -24.6440/DTHER ADMINISTRATIVE AND 5.06 O 45.00 MI OTHER REVENUES DURCHASE B -24.0440/DTHER ADMINISTRATIVE AND 5.06 O 45.00 MI OTHER REVENUES DURCHASE B -24.0440/DTHER ADMINISTRATIVE AND 5.06 O 45.00 MI OTHER REVENUES B -23.30/DEMERAL DEMERAL D 0.0 45.00 MI OTHER REVENUES B -3.375/DTHER ADMINISTRATIVE AND 5.06 O 45.00 MI OTHER REVENUES B -3.375/DEMERAL ADMINISTRATIVE ADD 5.06 O 45.00 MI OTHER REVENUES <		MH PT FINANCE SVCS CONTRACT			CASHI ERI NG/ACCOUNTS			
41.00 IH ADM IN ISTRATI VE AND LABOR -5.06 0 42.00 IH EDUCATION CLASS REVENUE B -12.512(0THER ADM) IN STRATI VE AND SERVENUE 5.06 0 43.00 IH MOSCULTI ONS-ADM RENTAL B -31.420(0THER ADM) IN STRATI VE AND SERVENUE 5.06 0 44.00 IM ACCOUNT IN GVENDOR REBATES B -24.44(0THER) AND INSTRATI VE AND SERVENUE 5.06 0 45.00 IH OTHER REVENUES PROCHASE DISCOUNTS B -24.44(0THER) AND INSTRATI VE AND SERVENUE 5.06 0 50.01 IN OTHER REVENUES PROCHASE B B -2.2,644(0THER) AND INSTRATI VE AND SERVENUE 5.06 0 61.01 IN OTHER REVENUES B B -2.3,50(DTHER ADMINISTRATI VE AND SERVENUE 5.06 0 62.01 IN OTHER REVENUES B B -2,059(NURSI NG ADMINISTRATI VE AND SERVENUE 5.06 0 63.01 IN CLARS REVENUES B -3.13 (NURSI NG ADMINISTRATI VE AND SERVENUE 5.06 0 64.00 INSCELLANEOUS INCO INSCELLANEOUS INCO B -2,059(NURSI NG ADMINISTRATI VE AND SERVENUE 5.06 0 65.00 INSCELANADOUS INCO B	40.00		А	-144, 406	OTHER ADMINISTRATIVE AND	5.06	0	40.00
Constructions Construc	41.00		А	-382, 287	OTHER ADMINISTRATIVE AND	5.06	0	41.00
INCOME INCOME CERTRAL 44.00 MH ACCUNTING VENDOR REBATES B -20,440 THER ADMINISTRATIVE AND GENERAL 5.06 0 45.00 MH OTHER REVENUES PURCHASE B -4,040 THER ADMINISTRATIVE AND GENERAL 5.06 0 45.00 MH OTHER REVENUES REAPPOINTIMENT FEES B -3,350 THER ADMINISTRATIVE AND GENERAL 5.06 0 45.02 MH OTHER REVENUES B -3,350 THER ADMINISTRATIVE AND GENERAL 5.06 0 45.02 MI OTHER REVENUES B -0,775 THER ADMINISTRATIVE AND GENERAL 5.06 0 45.03 MI OTHER REVENUES B -1,397 MIRSING ADMINISTRATIVE AND GENERAL 13.00 0 45.04 MORE THER REVENUES B -2,059 MIRSING ADMINISTRATIVE AND GENERAL 13.00 0 45.05 MI OTHER REVENUES B -2,059 MIRSING ADMINISTRATIVE AND GENERAL 15.00 0 45.06 MI OTHER REVENUES XEROX AND GENERAL B -2,059 MIRSING ADMINISTRATIVE AND GENERAL 15.00 0 45.07 MI COMA OUTREACH CONTRACT LABOR A -34,410 ADULTS & PEDIATRICS<					GENERAL			
Construct Construct <thconstruct< th=""> <thconstruct< th=""> <thc< td=""><td></td><td>I NCOME</td><td></td><td></td><td>GENERAL</td><td></td><td></td><td></td></thc<></thconstruct<></thconstruct<>		I NCOME			GENERAL			
DISCOUNTS CENTRAL 65.01 MI OTHER REVENUES B -3.00THER ADMINISTRATIVE AND GENERAL 5.06 0 65.02 MI OTHER REVENUES B -3.00THER ADMINISTRATIVE AND GENERAL 5.06 0 65.03 MI CLUNTR/DIA BE D CLASS B -1.13PNURSING ADMINISTRATIVE AND GENERAL 5.06 0 65.04 MI CLUNTR/DIA BE D OTHER B -2.359NURSING ADMINISTRATION 13.00 0 65.04 MI CLUNTR/DIA BE D OTHER B -2.359NURSING ADMINISTRATION 13.00 0 65.06 MI PARAMACY VENDOR REBATES B -5.096/PHARMACY 15.00 0 65.07 MI COMM. OUTBEACH CONTRACT A -34, 410ADULTS & PEDIATRICS 30.00 0 65.08 MI OTHER REVENUES BABY PHOTO B -405ADULTS & PEDIATRICS 30.00 0 65.09 MI OTHER REVENUES BABY PHOTO B -405ADULTS & PEDIATRICS 30.00 0 65.00 MI REHAB SUSCS-SWK CONTRACT A -91.920PHYSICAL THERAPY 66.00 0 64.00 MI REHAB SUPLY VENDOR<					GENERAL		-	
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Heal th	Financial Systems		MAJOR HO	SPI TAL	In Lie	eu of Form CMS-2	2552-10
	MENTS TO EXPENSES				Period: From 01/01/2015 To 12/31/2015		
					10 12/31/2013	4/28/2016 3:2	0 pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
	r	1.00	2.00	3.00	4.00	5.00	
45.35	HAF EXPENSE	A		INTENSIVE CARE UNIT	31.00		
45.36	HAF EXPENSE	A		OPERATING ROOM	50.00		
45.37	HAF EXPENSE	A		ANESTHESI OLOGY	53.00		
45.38	HAF EXPENSE	A		RADI OLOGY-DI AGNOSTI C	54.00		1 101 00
45.39	HAF EXPENSE	A		ONCOLOGY	56.01	0	
45.40	HAF EXPENSE	A	-103, 642		57.00		1 101 10
45. 41	HAF EXPENSE	A		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	RESPI RATORY 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		45.45
45.46	HAF EXPENSE	A		ELECTROCARDI OLOGY	69.00		
45.47	HAF EXPENSE	A		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		190.19	0	45.51
45.52	HAF EXPENSE	A	-9, 229	HOSPI TALI ST	192.01	0	45.52
45.53	HAF EXPENSE	A		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.

	Health Financial Systems		MAJOR HOSPITAL				In Lieu of Form CMS-2552-10			
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT			Provi der		Period:	Worksheet A-8	3-2	
							From 01/01/2015 To 12/31/2015			
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration		essi onal Iponent	Provider Component		Physician/Prov ider Component		
	1.00	2.00	3.00		4.00	5.00	6.00	Hours 7.00		
1.00		EMPLOYEE BENEFITS DEPARTMENT	28, 833		4.00 0	28, 833			1.00	
2.00		OTHER ADMINISTRATIVE AND GENERAL	28, 356		0	28, 356				
3.00	50.00	OPERATI NG ROOM	360, 000		360, 000	0	0	0	3.00	
4.00		ANESTHESI OLOGY	2, 189, 756		1, 770, 229	419, 527	-		4.00	
5.00		RADI OLOGY-DI AGNOSTI C	877, 288		877, 288	117, 027	207,100	2, 010	5.00	
6.00		ONCOLOGY	173, 404		151, 320	22, 084	271,900		6.00	
7.00		CT SCAN	2, 484	1	2, 484	0	0	0	7.00	
8.00		LABORATORY	55, 099		0	55,099	260, 300	726	8.00	
9.00		PHYSI CAL THERAPY	8, 333		0	8, 333			9.00	
10.00	69.00	ELECTROCARDI OLOGY	57, 440		57, 440	0	0	0	10.00	
11.00		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	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Per	rcent of	Cost of	Provi der	Physician Cost		
		I denti fi er	Limit	Unadj ι	usted RCE	Memberships &	Component	of Mal practi ce		
				Ĺ	imit.	Conti nui ng	Share of col.	Insurance		
						Educati on	12			
	1.00	2.00	8.00		9.00	12.00	13.00	14.00		
1.00		EMPLOYEE BENEFITS DEPARTMENT	25, 817		1, 291	0			1.00	
2.00		OTHER ADMI NI STRATI VE AND GENERAL	25, 817		1, 291	0		Ĵ	2.00	
3.00		OPERATI NG ROOM	0		0	0	-	0	3.00	
4.00		ANESTHESI OLOGY	266, 563		13, 328	0	-	0	4.00	
5.00		RADI OLOGY-DI AGNOSTI C	0		0	0	0	0	5.00	
6.00		ONCOLOGY	17, 255		863	0	0	0	6.00	
7.00					4 543	0	0	0	7.00	
8.00 9.00		LABORATORY PHYSI CAL THERAPY	90, 855 6, 885		4, 543 344	0	0	0	8.00 9.00	
9.00 10.00		ELECTROCARDI OLOGY	0, 885		344 0	0	0	0	9.00 10.00	
10.00		CLINIC	46, 557		2, 328	0	0	0	11.00	
12.00		EMERGENCY	285, 195		2, 320 14, 260	0	0	0	12.00	
200.00	91.00	EWERGENET	764, 944		38, 248	0	0	0		
	Wkst. A Line #	Cost Center/Physician	Provi der		sted RCE	RCE	Adjustment	0	200.00	
	intot. A Erno #	I denti fi er	Component		.imit	Di sal I owance	naj as tillorre			
			Share of col.							
			14							
	1.00	2.00	15.00	1	6.00	17.00	18.00			
1.00		EMPLOYEE BENEFITS DEPARTMENT	0		25, 817	3, 016			1.00	
2.00	5.06	OTHER ADMINISTRATIVE AND	0		25, 817	2, 539	2, 539		2.00	
		GENERAL	_			_				
3.00		OPERATI NG ROOM	0		0	0			3.00	
4.00		ANESTHESI OLOGY	0		266, 563	152, 964			4.00	
5.00		RADI OLOGY-DI AGNOSTI C	0		47.055	0	877, 288		5.00	
6.00		ONCOLOGY	0		17, 255	4, 829			6.00	
7.00			0			0	2,484		7.00	
8.00			0		90, 855 4 995	1 440	0		8.00	
9.00		PHYSI CAL THERAPY	0		6, 885	1, 448			9.00	
10.00		ELECTROCARDI OLOGY	0		0	0	57, 440		10.00	
11.00			0	•	46, 557	41, 176			11.00	
12.00	91.00	EMERGENCY	0	•	285, 195	373, 976			12.00 200.00	
200.00		1	0	I	764, 944	579, 948	3, 886, 248	1	200.00	

	Financial Systems	MAJOR HC	SPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2015	Worksheet B Part I	
					o 12/31/2015	Date/Time Pre	
			CAPI TAL			4/28/2016 3:2	0 pm
			RELATED COSTS				
	Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	COMMUNI CATI ONS	DATA	
		for Cost		BENEFITS		PROCESSI NG	
		Allocation		DEPARTMENT			
		(from Wkst A col. 7)					
		0	1.00	4.00	5. 01	5. 02	
	GENERAL SERVICE COST CENTERS				-		
1.00	00100 CAP REL COSTS-BLDG & FLXT	2, 555, 646					1.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS	7, 754, 530					4.00 5.01
5.01	00550 DATA PROCESSI NG	3, 452, 411				3, 697, 443	1
5.03	00590 PURCHASING, RECEIVING, AND STORES	337, 900				18, 674	
5.04	00570 ADMI TTI NG	1, 060, 429				186, 740	
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 552, 896		107, 465		105, 819	
5.06 7.00	00592 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	6, 828, 617 2, 141, 031				311, 233 93, 370	
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	2, 141, 031				6, 225	1
9.00	00900 HOUSEKEEPING	1, 202, 268				168, 066	
10.00	01000 DI ETARY	225, 216				118, 268	1
11.00		413, 583				0	
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	1, 212, 411	33, 170 62, 695		3 1, 443 195	87, 145 18, 674	
14.00	01500 PHARMACY	6, 117, 082				68, 471	1
16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 103, 336				105, 819	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6, 411, 158				572, 666	
31.00	03100 I NTENSI VE CARE UNI T	1, 395, 772				118, 268	
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0	-		0	
42.00	ANCI LLARY SERVICE COST CENTERS	0	0		<u>, </u>	0	42.00
50.00	05000 OPERATI NG ROOM	3, 972, 046	191, 928	589, 722	1, 911	261, 435	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	873, 152				43, 573	1
54.00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	3, 903, 794	183, 157	416, 116		211, 638	
56. 00 56. 01	05601 ONCOLOGY	1, 784, 351		222, 395	-	0 112, 044	
57.00	05700 CT SCAN	717, 323		62, 790		18, 674	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	654, 145		61, 530		24, 899	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	
60.00		4, 345, 674	39, 517	363, 728	858	248, 986	
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	972, 743	16, 477	159, 305	, v	0 68, 471	
65.00	06501 SLEEP LAB	583, 181		79, 781		37, 348	
66.00	06600 PHYSI CAL THERAPY	1, 921, 928				124, 493	
	06900 ELECTROCARDI OLOGY	569, 018					69.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	1, 508, 875		9, 982		18, 674	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	1, 487, 423	0	8, 214		0	
75.00	OUTPATIENT SERVICE COST CENTERS	0	0		/ U	0	/ 3. 00
88.00	08800 RURAL HEALTH CLINIC	0	0	C	0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C		0	
90.00	09000 CLINIC	41,016				24, 899	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 252, 519	104, 478	471, 859	819	224, 087	91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	0	0	C	0 0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	C	0	0	97.00
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	C	0 0		100.00
101.00	10100 HOME HEALTH AGENCY	1, 311, 621	0	153, 025	0	74, 696	101.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	1	1				113.00
118.00		71, 891, 586	2, 489, 049	7, 189, 065	20, 051	3, 535, 602	
	NONREI MBURSABLE COST CENTERS			.,			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7, 332	C	0 0		190.00
	19001 SHELBY COUNTY MEDICAL CENTER	0	0	C	0		190.01
	19002 SI CK CHI LD CARE 19003 PRI VATE DUTY		0				190. 02 190. 03
	19003 PRIVATE DUTY 19004 ST. VINCENT'S STRESS		0				190.03
	19005 MARKETI NG	366, 038	3, 784	42, 185	i 0		190.05
190.06	19006 MH LI GHTBOUND	0	0	C	0	0	190.06
	19007 I -74 CAMPUS	655, 055	0	29, 384	0		190.07
	19008 SOUTHEAST OB 19009 INTELLIPLEX DEVELOPMENT	0 91, 653	0		0		190. 08 190. 09
	19009 INTELLIPLEX DEVELOPMENT	91,053	0	2, 463 0			190.09
	19011 OTHER NON-REIMBURSEABLE CENTERS	0	0	c c			190. 11
		•	, -		, -1		•

Health Financial Systems	MAJOR HO	SPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATI ON - GENERAL SERVI CE COSTS		Provi der		Peri od: Worksheet E From 01/01/2015 Part I To 12/31/2015 Variation 4/28/2016		pared: 0 pm	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL <u>RELATED COSTS</u> BLDG & FI XT	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	PROCESSI NG		
	0	1.00	4.00	5. 01	5.02		
190. 12 19012 BARTLEY ORTHOPEDI CS	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	47,853	0	77:	3 0	0	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	1, 276, 967	5, 203	(0 0	0	190. 19	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0 0	0	192.00	
192. 01 19201 H0SPI TALI ST	2,077,474	0	371, 20	5 39	56, 022	192.01	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	834, 187	50, 278	130, 098	3 585	62, 247	194.00	
200.00 Cross Foot Adjustments						200.00	
201.00 Negative Cost Centers		0	(o o	0	201.00	
202.00 TOTAL (sum lines 118-201)	77, 240, 813	2, 555, 646	7, 765, 173	3 20, 675	3, 697, 443	202. 00	

	Financial Systems	MAJOR HOS	SPI TAL		In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der		riod: rom 01/01/2015 12/31/2015	Worksheet B Part I Date/Time Pre 4/28/2016 3:2	pared:
	Cost Center Description	PURCHASING, RECEIVING, AND STORES	ADMI TTI NG	CASHI ERI NG/ACC OUNTS RECEI VABLE	Subtotal	OTHER ADMI NI STRATI VE AND GENERAL	
		5.03	5.04	5.05	5A. 05	5. 06	
	GENERAL SERVICE COST CENTERS	-1					
1.00 4.00 5.01 5.02	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNICATIONS 00550 DATA PROCESSING						1.00 4.00 5.01 5.02
5.03 5.04 5.05	00590 PURCHASI NG, RECEI VI NG, AND STORES 00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	416, 108 4, 201 3, 072	1, 474, 609 0				5. 03 5. 04 5. 05
5.06	00592 OTHER ADMINISTRATIVE AND GENERAL	7,055	0		8, 179, 411	8, 179, 411	5.06
7.00	00700 OPERATION OF PLANT	526	0	0	2, 617, 094	309, 961	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	14	0	0	239, 921	28, 416	
9.00	00900 HOUSEKEEPING	6, 492	0		1, 534, 412	181, 731	9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	3, 696	0		429, 770		
13.00	01300 NURSI NG ADMI NI STRATI ON	7,653	0	0	566, 455 1, 559, 840		
14.00	01400 CENTRAL SERVICES & SUPPLY	13, 334	0	-	94, 898		
15.00	01500 PHARMACY	4, 269	0	-	6, 388, 204	756, 600	
16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 829	0	0	1, 415, 362	167, 631	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	51, 684	85, 205		8, 788, 312		
31.00	03100 I NTENSI VE CARE UNI T	23, 822	21, 558		1, 945, 871	230, 463	
41.00	04100 SUBPROVI DER – I RF	0	0		0	0	
42.00	04200 SUBPROVI DER ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	42.00
50.00	05000 OPERATING ROOM	106, 738	193, 961	232, 713	5, 550, 454	657, 379	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0,000,101	0	52.00
53.00	05300 ANESTHESI OLOGY	19, 899	6, 924	8, 307	1, 454, 054	172, 214	
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 880	126, 398	151, 650	5, 003, 569	592, 608	54.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	
56.01	05601 ONCOLOGY	12, 811	62, 929		2, 599, 469	307, 873	
57.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	4,649	116, 165		1, 066, 858		
58.00 59.00	05900 CARDI AC CATHETERI ZATI ON	2, 237	56, 478 0	67, 762 0	867, 051 0	102, 691 0	58.00 59.00
60.00	06000 LABORATORY	41, 406	203, 804	-	5, 488, 495		
60.01	06001 BLOOD LABORATORY	0	0	0	0, 100, 170	0	60.01
65.00	06500 RESPI RATORY THERAPY	6, 093	21, 848	26, 213	1, 272, 398	150, 699	65.00
65.01	06501 SLEEP LAB	3, 705	23, 199		755, 204	89, 444	65.01
66.00	06600 PHYSI CAL THERAPY	6, 786	37, 360		2, 434, 886		
69.00	06900 ELECTROCARDI OLOGY	8, 976	31, 221	37, 459	859, 551	101,803	
71.00 72.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	53, 832 44, 298		1, 655, 949 1, 593, 083		
72.00	07300 DRUGS CHARGED TO PATIENTS	0	134, 007		294, 787	34, 914	
10100	OUTPATIENT SERVICE COST CENTERS		1017007	100,100	2717707	017711	10100
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 CLI NI C	1, 367	1, 260		214, 904		
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	40, 484	241, 722	290, 049	4, 626, 017	547, 892	
92.00	OTHER REIMBURSABLE COST CENTERS				0		92.00
95 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	8, 322	12, 440	14, 925	1, 575, 029	186, 542	101.00
	SPECIAL PURPOSE COST CENTERS	1 1		1			
	11300 INTEREST EXPENSE	404 000	4 474 400	4 7/0 050	74 074 000	7 440 744	113.00
118.00	SUBTOTALS SUBTOTALS <thsub< th=""> SUB SUB</thsub<>	401,000	1, 474, 609	1, 769, 252	71, 071, 308	7, 448, 714	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7, 332	868	190.00
	19001 SHELBY COUNTY MEDICAL CENTER	0	0	0	0		190.01
	19002 SICK CHILD CARE	0	0	0	0		190. 02
190.03	19003 PRI VATE DUTY	0	0	0	0	0	190. 03
	19004 ST. VINCENT'S STRESS	0	0	0	0		190. 04
		0	0	0	424, 456		
	19006 MH LIGHTBOUND 19007 I-74 CAMPUS	57	0	0	0 715 410	0 84, 756	190.06
	1900711-74 CAMPUS 19008 SOUTHEAST OB	5/	0	0	715, 619 0		190.07
	19009 INTELLIPLEX DEVELOPMENT	0	0	0	94, 116		
	19010 MS&M	Ő	0	Ő	0		190.10
	19011 OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0		190. 11
190.12	19012 BARTLEY ORTHOPEDICS	0	0	0	0		190. 12
	19013 SSA	0	0	0	0		190.13
	19014 SPORTSWORKS 19015 SHELBY PEDS	0	0	0	0		190. 14 190. 15
190.15	JITO JOILLUI FLUO	I U	0	0	0	0	1170. 15

Health Financial Systems	MAJOR HOS	SPI TAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150097	Period: From 01/01/2015	Worksheet B Part I	
				To 12/31/2015	Date/Time Pre	
				-	4/28/2016 3:2	0 pm
Cost Center Description	PURCHASI NG,	ADMI TTI NG	CASHI ERI NG/AG	CC Subtotal	OTHER	
	RECEIVING, AND		OUNTS		ADMI NI STRATI VE	
	STORES		RECEI VABLE		AND GENERAL	
	5.03	5.04	5.05	5A. 05	5.06	
190. 16 19016 RENOVO	0	C)	0 48, 626	5, 759	190. 16
190. 17 19017 I MA	0	0		0 0	0	190. 17
190. 18 19018 MD SOLUTI ONS	0	C		0 0	0	190. 18
190. 19 19019 MHCD	0	C		0 1, 282, 170	151, 856	190. 19
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	C		0 0	0	192.00
192. 01 19201 HOSPI TALI ST	8	C		0 2, 504, 748	296, 655	192.01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	15, 043	C		0 1,092,438	129, 385	194.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers	0	C		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	416, 108	1, 474, 609	1, 769, 25	52 77, 240, 813		

	Financial Systems	MAJOR HO				u of Form CMS-	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part I Date/Time Pre 4/28/2016 3:2	pared:
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			1	1		1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160 COMMUNI CATI ONS						5.01
5.02 5.03	00550 DATA PROCESSING 00590 PURCHASING, RECEIVING, AND STORES						5.02 5.03
5.04	00570 ADMI TTI NG						5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5.06 7.00	00592 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	2, 927, 055					5.06 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	15, 638					8.00
9.00	00900 HOUSEKEEPING	7, 241	0	.,,			9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	69, 369 109, 858	0	41, 165 65, 191		808, 593	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	47, 420	0	28, 140		29, 192	•
14.00	01400 CENTRAL SERVICES & SUPPLY	89, 628		53, 186		0	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	40, 799 62, 072	0	,		22, 224 34, 178	•
	INPATIENT ROUTINE SERVICE COST CENTERS		-				
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	683, 912 209, 432	109, 635			183, 908	•
31.00 41.00	04100 SUBPROVIDER – IRF	209, 432	17, 038 0			38, 068 0	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	
50.00	ANCI LLARY SERVI CE COST CENTERS	274, 377	39, 579	162, 820	ol	82, 299	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			02,277	
53.00	05300 ANESTHESI OLOGY	13, 271	0			18, 350	•
54.00 56.00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	261, 839	34, 485	155, 379		59, 885 0	54.00 56.00
56.01	05601 ONCOLOGY	468, 227	0		, ,	35, 272	•
57.00	05700 CT SCAN	11, 270	0	6, 688		11, 244	•
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	0				9, 948 0	
60.00	06000 LABORATORY	56, 493	7, 927	33, 524	0	79, 341	60.00
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0 23, 555	0	0 13, 978		0	60. 01 65. 00
65.00	06501 SLEEP LAB	23, 555	0	13, 976		22, 511 0	
66.00	06600 PHYSI CAL THERAPY	17, 751	11, 192			41, 014	
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	79, 541	2, 737			17, 747 3, 406	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	-	-	2, 723	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	с с	0	0	73.00
88 00	OUTPATI ENT_SERVI CE_COST_CENTERS 08800 RURAL_HEALTH_CLINI C	0	0			0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	c c	0	0	1
90.00		140, 795				8, 354	•
91.00 92.00		149, 361	60, 303	88, 633	5 U	75, 444	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS	1	1	1			
	09500 AMBULANCE SERVI CES 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0			0	
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0		-		100.00
101.00	0 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
113.00	SPECIAL PURPOSE COST CENTERS						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2, 831, 849	283, 877	1, 666, 887	591, 205	775, 108	•
100.00	NONREI MBURSABLE COST CENTERS	10 401	0	())		0	100.00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1 19001 SHELBY COUNTY MEDICAL CENTER	10, 481	0	6, 220 (190. 00 190. 01
190.02	2 19002 SI CK CHI LD CARE	0	0	c c	0	0	190. 02
	3 19003 PRI VATE DUTY 4 19004 ST. VI NCENT' S STRESS	0	0	0	0		190. 03 190. 04
	5 19004 ST. VINCENT S STRESS 5 19005 MARKETI NG	5, 410	0	3, 210			190.04
	5 19006 MH LI GHTBOUND	0	0	C	0 0		190. 06
	7 19007 I - 74 CAMPUS 3 19008 SOUTHEAST OB	0	0				190. 07 190. 08
	9 19009 INTELLIPLEX DEVELOPMENT	0	0				190.08
190.10	D 19010 MS&M	0	0	c c	0	0	190. 10
	1 19011 OTHER NON-REI MBURSEABLE CENTERS 2 19012 BARTLEY ORTHOPEDI CS	0					190. 11 190. 12
	3 19013 SSA	0	0			0	190. 13
	1 19014 SPORTSWORKS	0	0	C	0		190.14
	5 19015 SHELBY PEDS 5 19016 RENOVO						190. 15 190. 16
			. 0		<u> </u>	0	

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period:	Worksheet B	
				From 01/01/2015 To 12/31/2015	Part I Date/Time Prep	pared:
					4/28/2016 3:20	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	G DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	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 SOLUTI ONS	0	0		0 0	0	190. 18
190. 19 19019 MHCD	7, 438	0	4, 41	4 0	0	190. 19
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
192. 01 19201 HOSPI TALI ST	0	0		0 0	17, 425	192. 01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	71, 877	98	42, 65	53 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, 38	591, 205	808, 593	202.00

Health Financial Systems	MAJOR HOS	SPI TAL		In Lieu	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		eriod: rom 01/01/2015	Worksheet B Part I	
			Т	b 12/31/2015	Date/Time Pre 4/28/2016 3:2	
Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	Subtotal	
		SUPPLY	45.00	LI BRARY	04.00	
GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	24.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 01160 COMMUNI CATI ONS						4.00 5.01
5. 02 00550 DATA PROCESSI NG						5. 02
5. 03 00590 PURCHASING, RECEIVING, AND STORES 5. 04 00570 ADMITTING						5.03 5.04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5. 06 00592 OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9.00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A						10.00
13.00 01300 NURSING ADMINISTRATION	1, 849, 335					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0	248, 951 0	7, 232, 038			14.00 15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0	7, 232, 038	1, 716, 077		16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F07 025	0		117 07/	10 454 447	
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	597, 235 123, 622	0	0	117, 376 23, 124	12, 456, 667 2, 773, 503	
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42. 00 04200 SUBPROVI DER ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	42.00
50. 00 05000 OPERATI NG ROOM	267, 260	0	0	223, 429	7, 257, 597	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0 59, 591	0	0	0 7, 975	0 1, 733, 330	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0, 57	0	0	145, 598	6, 253, 363	
56. 00 05600 RADI 0I SOTOPE	0	0	0	0	0	
56. 01 05601 ONCOLOGY 57. 00 05700 CT_SCAN	114, 544 0	0	0	72, 488 133, 811	3, 875, 727 1, 356, 226	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	65, 057	1, 044, 747	58.00
59. 00 05900 CARDI AC_CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	0	0	0 234, 762	0 6, 550, 583	
60. 01 06001 BLOOD LABORATORY	0	0	0	234, 782	0	60. 01
65. 00 06500 RESPI RATORY THERAPY 65. 01 06501 SLEEP LAB	73, 103	0	0	25, 167	1, 581, 411 913, 474	
66. 00 06600 PHYSI CAL THERAPY	42, 103 0	0	0	26, 723 43, 036	2, 846, 794	1
69. 00 06900 ELECTROCARDI OLOGY	57, 631	0	0	35, 964	1, 202, 175	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	136, 923 112, 028	0	62, 009 51, 027	2, 054, 413 1, 947, 541	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	7, 232, 038	154, 363	7, 716, 102	
0UTPATI ENT SERVI CE 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 91. 00 09100 EMERGENCY	27, 128 245, 001	0	0	1, 451 278, 387	502, 616 6, 071, 038	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	243,001	0	0	270, 307	0, 071, 038	92.00
		0		d	0	
95. 00 09500 AMBULANCE SERVICES 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0 0	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	80, 978	0	0	14, 330	1, 856, 879	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	1, 688, 196	248, 951	7, 232, 038	1, 716, 077	69, 994, 186	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	24, 901	190. 00
190. 01 19001 SHELBY COUNTY MEDICAL CENTER	0	0	0	0		190.01
190. 02 19002 SI CK CHI LD CARE 190. 03 19003 PRI VATE DUTY	0	0	0	0		190. 02 190. 03
190. 04 19004 ST. VINCENT' S STRESS	0	0	0	0	0	190. 04
190. 05 19005 MARKETI NG 190. 06 19006 MH LI GHTBOUND	0	0	0	0	489, 263 0	190. 05 190. 06
190. 07 1900 MIT ET GITBOUND 190. 07 19007 I - 74 CAMPUS	30, 772	0	0	0	840, 623	190. 07
190. 08 19008 SOUTHEAST OB	0	0	0	0		190.08
190. 09 19009 I NTELLI PLEX DEVELOPMENT 190. 10 19010 MS&M	2, 169 0	0	0	o	108, 100 0	190. 09 190. 10
190. 11 19011 OTHER NON-REI MBURSEABLE CENTERS	0	0	0	ō	0	190. 11
190. 12 19012 BARTLEY ORTHOPEDI CS 190. 13 19013 SSA	0	0		0		190. 12 190. 13
190. 14 19014 SPORTSWORKS	0	0	0	0 0	0	190. 14
190. 15 19015 SHELBY PEDS	0	0	0	0	0	190. 15

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150097	Period:	Worksheet B	
				From 01/01/2015 To 12/31/2015		nared
				10 12/01/2010	4/28/2016 3:2	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		SUPPLY		LI BRARY		
	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 I MA	0	0		0 0	0	190. 17
190. 18 19018 MD SOLUTI ONS	0	0		0 0	0	190. 18
190. 19 19019 MHCD	0	0		0 0	1, 445, 878	190. 19
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
192. 01 19201 HOSPI TALI ST	56, 588	0		0 0	2, 875, 416	192.01
194.0007950 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, 0	38 1, 716, 077	77, 240, 813	202.00

4.00 00400 EPRLYTE BEREFTS DEPARTMENT 4 5.00 0166 CONMIN CATIONS 5 5.00 00550 DATA PROCESSING 5 5.00 00550 DATA PROCESSING 5 5.00 00580 CASH EXENSACEUNIS RECEVINGLE 7 5.00 00580 CASH EXENSACEUNIS RECEVINGLE 7 5.00 00580 CASH EXENSACEUNIS RECEVINGLE 11 5.00 00580 CASH EXENSACEUNIS RECEVINGLE 13 5.00 00580 CASH EXENSACEUNIS RECEVINGLE 13 5.10 00580 CASH EXENSACEUNIS RECEVINGLE 13 5.10 00580 CASH EXENSACEUNIS RECEVINGLE 14 5.10 00580 CASH EXENSACEUNIS RECEVINGLE 12.456, 667 5.10 00590 CASH EXENSACEUNIS RECEVINGLE 0 5.10 00590 CASH EX		Financial Systems LLLOCATION - GENERAL SERVICE COSTS	MAJOR HOSP	Provider CCN:	: 150097	Period: From 01/01/2015	u of Form CMS Worksheet B Part I Date/Time Pro	epared:
DEFENSE SERVICE COST CENTERS 1 1 00 00100 ENVIDES EDEFT IS DEPARTMENT 4 4 00 00100 ENVIDES EDEFT IS DEPARTMENT 4 5 00 0000 ENVIDES EDEFT IS DEPARTMENT 5 5 00 0000 ENVIDES EDEFT IS DEPARTMENT 5 5 00 0000 ENVIDES EDEFT IS DEPARTMENT 5 6 00 0000 ENVIDES EDEFT IS DEPARTMENT 5 7 00 0000 ENVIDES EDEFT IS DEPARTMENT 5 7 00 0000 ENVIDES ENVIDES ADD OF DEPERAL 7 8 00 0000 ENVIDES ENVIDES ADD OF DEPERAL 7 10 00 0000 ENVIDES ENVIDES ADD OF DEPERAL 7 7 10 00 0000 ENVIDES ENVIDES ADD OF DEPERAL 7 7 10 00 0000 ENVIDES ADD OF DEPERAL 7 7 8 10 00 0000 ENVIDES ADD OF DEPERAL 7 7 8 10 00 0000 ENVIDES ADD OF DEPERAL 7 7 7 7 10 00 0000 ENVIDES ADD OF DEPERAL 0 7 7 7 7 7 10 00 0000 ENVIDES ADD OF DEPERAL 0 7 7 7 <t< th=""><th></th><th>Cost Center Description</th><th>Residents Cost & Post Stepdown Adjustments</th><th></th><th></th><th></th><th>4/28/2016 3::</th><th>20 pm</th></t<>		Cost Center Description	Residents Cost & Post Stepdown Adjustments				4/28/2016 3::	20 pm
4 00 00400 DEPLOYCE BERGET TS DEPARTMENT 5 5 00 014050 DATA PROCESSING 5 5 00 00500 DATA PROCESSING 5 6 00500 DATA PROCESSING 7 7 7 00 00500 DATA PROCESSING 11 11 01400 DATA PROCESSING 11 11 01400 DATA PROCESSING 12 450 11 01400 DATA PROFESSING 12 450 11 01400 DATA PROFESSING 12 450 11 01400 DATA PROFESSING 12 <		GENERAL SERVICE COST CENTERS	20.00	20.00				
31 0.0 03100 [INTERNS VE CARE LINIT 0 2,773,503 31.1 11.00 04100 SUBRROW DER 0 0 41.1 42.00 05000 (PERATI NG ROM 0 7,257,597 50.00 50.00 05300 (PERATI NG ROM 0 7,257,597 50.00 50.00 05300 (PERATI NG ROM 0 7,257,597 56.00 53.00 05300 (ANESTICE) (C.C) 0 6,253,363 54. 56.00 05600 (RADI DISTOPE 0 0 6,253,363 54. 56.00 05600 (RADI DISTOPE 0 1,366,226 57. 56. 57.00 05700 (CT SCAN 0 1,366,226 57. 56. 66.00 60.00	$\begin{array}{c} 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG 00590 PURCHASI NG, RECEI VI NG, AND STORES 00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00592 OTHER ADMI NI STRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY INPATI ENT ROUTI NE SERVI CE COST CENTERS						$\begin{array}{c} 1.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
11.00 04100 SUBPROVIDER 1.8F 0 0 41.1 21.00 4220 4220 4220 4220 4220 MACILLARY SERVICE COST CONTRES 50			-					30.00
90.00 0 0 7, 257, 597 50. 52.00 05200 DELL'DERY ROW & LABOR ROW 0 1, 733, 330 53. 54.00 05400 ARDI DLGY-TI GROSTIC 0 6, 253, 363 54. 56.00 05600 RADI DLGY-TI GROSTIC 0 6, 253, 363 54. 56.01 05600 RADI DLGY-TI GROSTIC 0 7, 257, 597 56. 57.00 0 57, 727 56. 57. 58.00 05500 CLASDMACE LIAGING (MRI) 0 1, 345. 226 57. 59.00 0.5500 CLASDMACE ATHETERIZATION 0 0 60. 6500. 6500 CLASDMATCRY 0 6. 59. 60. 66.00 66.00 6500 FESPI RATORY 0 1, 381, 411 65. 66.00 66.00 66.00 66.00 66.00 6500 FESPI RATORY 0 1, 202, 175. 69. 69. 0 69. 0 69. 69.00 69.00 1, 202, 175. 69. 73. 73. 73. 73. 73. 73. 73. <t< td=""><td>41.00</td><td>04100 SUBPROVI DER – I RF 04200 SUBPROVI DER</td><td>0</td><td>0</td><td></td><td></td><td></td><td>31.00 41.00 42.00</td></t<>	41.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0				31.00 41.00 42.00
53.00 05300 ANESTRESI OLOGY 0 1, 733, 330 53. 54.00 05600 RADI DLOY-DI AGNOSTIC 0 6, 53, 363 54. 56.00 05600 RADI DLOY-DI AGNOSTIC 0 75. 56. 57.00 05700 CRSDI ALC-STREET 56. 57. 56. 58.00 05600 KARSTIC RESONANCE I MAGI NG (MRI) 0 1, 346, 226 57. 59.00 05900 CARDIA CATHETERI ZATI ON 0 0 60. 60.00 06000 LABORATORY 0 6, 550, 583 60. 60.00 06000 LABORATORY 0 1, 347, 44 65. 65.00 06500 CRSPIR ATORY HERAPY 0 1, 547, 744 65. 66.00 06600 HESPI RATORY HERAPY 0 1, 347, 341 65. 67.00 06700 LABORATORY 0 1, 202, 175 66. 69.00 06700 LABORATORY 1, 447, 541 72. 73. 70.00 07200 IHVEL CALSURGED TO PATI ENTS 0 7, 74. 65. 69.00 06700 CIRCACARATERICE TO PATI ENTS 0 7, 74. 74. 70.00 07200 IHVEL CALSURGED TO PATI ENTS 0 7, 74.	50.00		0	7, 257, 597				50.00
94 00 05400 RADIOLGGY-DIAGNOSTIC 0 6,253,363 54,65 95 00 05600 RADIOLSTOPE 0 0 3,875,727 56,6 95 00 05800 MARCHTIC RESONANCE IMAGING (MRI) 0 1,044,747 58,80 95 00 05800 CARDIA CATHETERI ZATION 0 6,550,583 60,00 96 00 00 0.00 0.00 0.00 60,00 96 00 00 0.00 0.00 0.00 60,00 96 00 0.00 0.00 0.00 0.00 60,00 96 00 0.00 0.00 0.00 0.00 60,00 96 00 0.00 0.00 0.00 0.00 60,00 97 10.00 0.00 0.00 0.00 0.00 0.00 90 00 0.01 0.01 0.00 0.01 0.01 91 100 0.01 0.01 0.01 0.01 0.01 92 00 0.01 0.00 0.00 0.01 0.00 93 00 0.01 0.01 0.01 0.01 0.00 94 00 0.01 0.01 0.01 0.01 0.01 95 00 0.000 0.000 0.01 <td></td> <td></td> <td>-</td> <td>-</td> <td></td> <td></td> <td></td> <td>52.00</td>			-	-				52.00
66.00 00 00 00 00 56.00 56.01 05600 NACI DI SOTOPE 0 3.75, 727 56. 57.00 05700 CT SCAN 0 1, 356, 226 57. 58.00 05800 LABRATORY 0 1, 044, 747 58. 59.00 05900 LABRATORY 0 6, 550, 583 60. 60.01 0600 LABRATORY 0 1, 581, 411 65. 61.01 06500 RESPI RATORY THERAPY 0 1, 581, 411 65. 62.01 06600 PHSTICAL THERAPY 0 1, 202, 175 69. 63.00 06600 PHSTICAL THERAPY 0 1, 202, 175 69. 71.00 07100 RELOF LAL SUPPLIES CHARGED TO PATIENT 0 2, 054, 413 71. 72. 73.00 07300 RUGS CHARGED TO PATIENT 0 502, 616 90. 90. 90. 90. 90. 90. 90. 90. 90. 90. 90.			0					53.00 54.00
57.00 OS700 (CT SCAN 0 1, 356, 226 57. 58.00 OS900 MAGNETI C RESONANCE I MAGING (MRI) 0 1, 044, 747 59.00 OS900 CARDIA C CATHETERIZATI ON 0 6, 550, 553 60.00 OS000 LABORATORY 0 6, 550, 553 60.00 OS00 RESPI RATORY THERAPY 0 1, 581, 411 65.01 OS000 RESPI RATORY THERAPY 0 1, 324, 474 66.00 OS000 RESPI RATORIO LUDOY 0 2, 846, 194 66.00 OS000 RESPI RATORIO LUDOY 0 2, 846, 194 71.00 OT300 RESPI RATORIO LUDOY 0 1, 202, 175 72.00 OT300 RESPI RATORIO LUDOY 0 1, 202, 175 72.00 OT300 RUSCAL SUPPLIES CHARGED TO PATIENTS 0 7, 716, 102 72.00 OT300 RUSCAL CARGED TO PATIENTS 0 7, 716, 102 73.00 OT300 RUSCAL CARGED TO PATIENTS 0 0 88.00 OB800 RURAL HEALTH CLIN C 0 0 89.00 OS900 OLEDERALLY OLLIFED HEALTH CENTER 0 0 90.00 OS00 OLEDERALY COLL FED HEALTH CENTER 0 0 91.00 OS00 OLEDERALY OLAL FED HEALTH CENTER 0 0 92.00 OS00 OLEDERALY COLAL FED HERS 90.			0	0				56.00
58:00 0SB00 MACHTIC RESONANCE I MAGI NG (NR1) 0 1,04,747 58. 59:00 0S000 CARDIA CCATHETERIZATION 0 6. 59. 60:00 0A000 CARDIA CCATHETERIZATION 0 6. 550. 60. 60:00 0A000 PLADICATHETERIZATION 0 13.474 65. 66. 60:00 0A000 PLOCIAL SUPLIES CHARGED TO PATIENTS 0 1,202,175 69. 71.00 07100 INDUE DCLAS URAGED TO PATIENTS 0 1,947,541 72. 73.00 07300 DRUGS CHARGED TO PATIENTS 0 7,76. 73. 73.00 07300 DRUGA CHARGED TO PATIENT 0 0 90. 90.00 PS000 CRUCAL CHARGED TO PATIENT 0 0 90. 90.00 0000 CRUCAL CEANGED TO PATIENT 0 0 90.			0					56.01
59 00 Osspol CARDIA C CATHETERI ZATI ON O Second Second <td></td> <td></td> <td>0</td> <td>1</td> <td></td> <td></td> <td></td> <td>57.00</td>			0	1				57.00
60.00 0c000 LABORATORY 0 6,55,583 60. 60.01 0c001 BLODD LABORATORY 0 0 0 65.01 0c500 RESPIRATORY THERAPY 0 1,581,411 65. 65.01 0c500 RESPIRATORY THERAPY 0 2,846,774 65. 66.00 0c600 PHYSI CAL THERAPY 0 2,284,774 66. 67.00 OMEDICAL SUPPLIES CHARGED TO PATIENTS 0 1,202,175 67. 71.00 OTOO MEDICAL SUPPLIES CHARGED TO PATIENTS 0 2,054,413 71. 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 7,74, 501 72. 00TPATIENT SERVICE COST CENTERS 0 0 0 89. 80.00 08000 RURAL HACHATH CLINIC 0 0 90. 90.00 90.00 00000 CLINIC 0 50. 90. 90.00 90.00 09000 CLINIC 0 50. 90. 97. 91.00 09100 DLIRABLE MEDICAL COST CENTERS 91. 92. 95. 91.00 09100 DLIRABLE MEDICAL			0	1,044,747				58.00
65:00 06500 RESPIRATORY THERAPY 0 1, 581, 411 65. 65:01 06501 SLEEP LAB 0 913, 474 65. 66:00 06600 PHYSI CAL THERAPY 0 1, 202, 175 66. 67:00 0700 MED CAL SUPPLIES CHARGED TO PATIENTS 0 2, 054, 413 71. 72:00 07200 IMPL, DEV. CHARGED TO PATIENTS 0 7, 716, 102 73. 0UTPATIENT SERVICE COST CENTERS 0 0 0 88. 88. 80:00 08900 RURAL HEALTH CLINC 0 0 89. 91. 91. 90:00 0000 CLINC 0 0 502, 616 90. 91. 90:00 09000 CLINC 0 0 0 97. 97. 90:00 0000 EMERCENCY 0 6,071,038 91. 92. 92.00 09500 AMBULANCE SERVICES 0 0 97. 90:00 00000 LEMERCENCY 0 1,856,879 101. 100. 90:00 0 <t< td=""><td></td><td></td><td>0</td><td>6, 550, 583</td><td></td><td></td><td></td><td>60.00</td></t<>			0	6, 550, 583				60.00
65.01 06501 SLEEP LAB 0 913, 474 65. 66.00 06600 PHYSICAL THERAPY 0 2, 846, 794 66. 67.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 1, 202, 175 67. 71.00 07200 IMPL, DeV. CHARGED TO PATIENTS 0 2, 054, 413 71. 72.00 07300 DRUGS CHARGED TO PATIENTS 0 7, 716, 102 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 7, 716, 102 73. 00 08800 RURAL HEALTH CLINIC 0 0 0 88. 89.00 08900 FUESCHARGENCY 0 6, 071, 038 99. 90. 91.00 09000 CLINIC 0 0 502, 616 90. 92. 91.00 09000 OBERVALTO BEDS (NON-DI STINCT PART) 0 0 91. 92. 92. 92. 95. 95. 95. 97. 000 09000 DURABLE MEDICAL EQUIP-SOLD 0 0 100. 100. 100.	60. 01	06001 BLOOD LABORATORY	0	0				60. 01
66:00 06:00 PHYSICAL THERAPY 0 2.846,794 66. 69:00 06:00 LECETOCARDIOLOGY 0 1.202,175 69. 71:00 07:00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 2.054,413 71. 72:00 07:200 IMPL DEV. CHARGED TO PATIENTS 0 7,716,102 73. 00000 DUTPATIENT SERVICE COST CENTERS 0 7,716,102 73. 0 73. 00000 OB:00 FDERALLY QUALIFIED HEALTH CENTER 0 0 88. 89.00 00:000 0 502,616 90. 91. 90:00 09:000 FDERALLY QUALIFIED HEALTH CENTER 0 0 0 90. 91. 92.00 09:000 CHARCHARTH ON BEDS (NON-DISTINCT PART) 0 50.00 950.0 95.00 0 90. 97. 0.00 90.00 97. 100.00 100.01 100.01 100.01 100.01 90. 97. 100.00 100.01 100.01 100. 100.			0					65.00
69:00 06900 ELECTROCARDIOLOGY 0 1, 202, 175 69, 71:00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 2, 054, 413 71. 71:00 07200 INPL. DEV. CHARGED TO PATIENT 0 1, 947, 541 72. 73:00 07300 DRUGS CHARGED TO PATIENT 0 7, 716, 102 73. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 90:00 09000 CLINAL HEALTH CLINIC 0 0 0 89. 90:00 09000 CLINC 0 502, 616 90. 91. 91:00 09000 CLINC CESTRO 0 6, 071, 038 91. 92. 0THER REINBURSABLE COST CENTERS 0 0 0 0 0 100. 90:00 09000 AUBLANCE SERVICES 0 0 0 100. 100. 90:00 09000 AUBLANCE SERVICES 0 0 0 100. 100. 100. 100. <td< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td></td><td>65.01</td></td<>			0					65.01
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 2, 054, 413 71. 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 1, 947, 541 72. 73.00 07300 DRUGS CHARGED TO PATIENTS 0 7, 716, 102 73. 000 0000 CRULE REALTH CLINIC 0 0 88. 80.00 08000 REALENTH CLINIC 0 0 90. 91.00 09000 CLINIC 0 502, 616 90. 91.00 09100 EMERGENCY 0 6, 071, 038 91. 92.00 09500 AMBULANCE SERVICES 0 0 92. 95.00 09500 AMBULANCE SERVICES 0 0 97. 95.00 09500 AMBULANCE SERVICES 0 0 97. 95.00 09500 AMBULANCE SERVICES 0 0 100. 95.00 09500 AMBULANCE SERVICES 0 0 100. 95.00 09500 AMBULANCE COST CENTERS 91. 13.00 11300 INTEREST EXPENSE 95.00 09500 AMBULANCE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 190.			0					69.00
73.00 D7300 DRUGS CHARGED TO PATLENTS 0 7, 716, 102 73. 0UTPATLENT SERVICE COST CENTERS 0 0 0 88. 88.00 D8800 RURAL HEALTH CLINIC 0 0 88. 89.00 D9800 FLDERALLY QUALIFIED HEALTH CENTER 0 0 89. 0 90.00 O9000 CLINIC 0 5.02, 616 90. 90. 91.00 D97000 DESERVATION BEDS (NON-DISTINCT PART) 0 6.071, 038 91. 92.00 O9200 OESERVATION BEDS (NON-DISTINCT PART) 0 0 92. 97. 00 D9500 AMBULANCE SERVICES 0 0 0 97. 95.00 O9500 AMBULANCE SERVICES NOT APPRVD PRGM 0 0 100. 101.00 HOME HEALTH ACENCY 0 1, 856, 879 101. SUBTOTALS (SUM OF LINES 1-1177) 0 69, 994, 186 113. 113.00 IT300 INTEREST EXPENSE 118. 118. 119. 0 90.01 9001 SPIELBY CONTY MEDI CAL CENTER 0 0 190. 190.01 190.02 19002 SI CK CHILD CARE 0<			0					71.00
OUTPATIENT SERVICE COST CENTERS Image: Cost Centers State 88.00 08800 RURAL HEALTH CLINIC 0 0 88. 89.00 08900 FEDERALLY QUALL FIED HEALTH CENTER 0 0 89. 90.00 09000 CLINIC 0 502,616 90. 91.00 09100 EMERGENCY 0 6,071,038 91. 92.00 09200 (DBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 92. 00700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 95. 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97. 101.00 1000 HANGE EREVICES 0 0 0 100. 101.00 1000 HANGE HEALTH AGENCY 0 1, 856, 879 101. 101. 113.00 11300 INTEREST EXPENSE 113. 69, 994, 186 113. 113. 113. 113. 113. 113. 113. 113. 113. 113. 113. 113. 114. 115. 116. 1			-					72.00
88.00 00 00 0 0 0 88. 89.00 00 0000 CLINIC 0 0 0 89. 90.00 09000 CLINIC 0 0 0 90. 09000 CLINIC 90. 0 90.00 90.00 EVERGENCY 0 6.071,038 91. 91. 92. 90.00 0005ERVATION BEDS (NON-DISTINCT PART) 0 6.0 90.00 97.00 09500 AMBULANCE SERVI CES NOT ZENTERS 95. 97. 00 970.00 970.00 970.00 970.00 970.00 970.00 0 0 97. 0 100.01 100.01 100.00 (JAUSELE MEDI CAL EQUI P-SOLD 0 0 100. 100.00 (JAUSEL MEDI CAL EQUI P-SOLD 0 0 100. 100.00 (JAUSEL MEDI CAL EQUI P-SOLD 0 100. 100.00 (JAUSEL MEDI CAL EQUI P-SOLD 0 1.856, 879 101. 101. 101. 101. 100.01 (JAUSEL MEDI CAL ECNT ES	73.00		0	7, 716, 102				73.00
89.00 09000 FEDERALLY QUALIFIED HEALTH CENTER 0 0 90. 90.00 90000 FEDERALLY QUALIFIED HEALTH CENTER 0 50.00 502,616 90. 90	88.00		0	0				88.00
91.00 09100 EMERGENCY 0 6,071,038 91. 92.00 09200 DBEES (NON-DI STINCT PART) 0 92.00 09500 AMBULANCE SERVICES 92.00 0 95.00 09500 AMBULANCE SERVICES 0 0 95.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97.00 00 0 100.00 1 88 SERVICES-NOT APPRVD PRGM 0 0 0 100. 100. 100. 100.01 100.04 HEALTH AGENCY 0 1,856,879 100. <			0	Ō				89.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART) O 92. OTHER REIMBURSABLE COST CENTERS 0 0 0 95.00 9500 AMBULANCE SERVICES 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 100. 100. 100. 100.0 100.0 1000 1000 1000 1000 1000 100.0 190.0 130.0 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 <td< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td></td><td>90.00</td></td<>			0					90.00
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI (CES 0 0 95. 100.00 1000 1& SERVI (CES 0 0 97. 00 00 97. 100.00 1& SERVI (CES-NOT APPRVD PRGM 0 0 100. 100. 101. 101. 101. 0 101. 0 101. 101. 101. 101. 101. 101. 101. 100. 101. 100. 101. 100. 101. 100. 101. 100. 101. 100. 101. 100. 101. 100. 113. 113. 113. 113.00 1NTEREST EXPENSE 113. 113. 113. 113.00 1NTEREST EXPENSE 114. 118. 118. 118. 100. 190.00 G FT, FLOWER, COFFEE SHOP & CANTEEN 24.901 190. 190. 190.0 190.01 190.01 190.01 190.01 190.01 190.01 190.01 190.01			-	6, 071, 038				91.00 92.00
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 97. 100.00 10000 I & SERVI CES-NOT APPRVD PRGM 0 0 100. 101.00 HOME HEALTH AGENCY 0 1, 856, 879 100. SPECI AL PURPOSE COST CENTERS 113.00 I NTEREST EXPENSE 113. 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 69, 994, 186 113. 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 69, 994, 186 113. 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 69, 994, 186 190. 190.00 IFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 190.01 19001 SHELBY COUNTY MEDI CAL CENTER 0 0 190. 190.02 19002 SI CK CHI LD CARE 0 0 190. 190. 190.03 19003 PRI VATE DUTY 0 0 190. 190. 190.04 19005 MARKETI NG 0 489, 263 190. 190.05 19005 MARKETI NG 0 0 190. 190.06 19006 MH LI GHTBOUND <td>72.00</td> <td></td> <td><u> </u></td> <td></td> <td></td> <td></td> <td></td> <td>/2.00</td>	72.00		<u> </u>					/2.00
100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100. 101.00 10100 HOME HEALTH AGENCY 0 1,856,879 101. SPECI AL PURPOSE COST CENTERS			0	0				95.00
101.00 10100 HOME HEALTH AGENCY 0 1,856,879 101. SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113. 113. 113.00 SUBTOTALS (SUM OF LINES 1-117) 0 69,994,186 113. NONREI MBURSABLE COST CENTERS 113. 190.00 19001 SHELBY COUNTY MEDI CAL CENTER 0 0 190. 190.01 19002 SI CK CHI LD CARE 0 0 190. 190. 190.02 19002 SI CK CHI LD CARE 0 0 190. 190. 190.03 19003 PRI VATE DUTY 0 0 190. 190. 190.04 19004 ST. VI NCENT'S STRESS 0 0 190. 190. 19007 1-74 CAMPUS 190. 190.05 19006 MARKETI NG 0 840,623 190. 190. 190.08 19008 SOUTHEAST OB 0 0 190. 190. 190. </td <td></td> <td></td> <td>-</td> <td>0</td> <td></td> <td></td> <td></td> <td>97.00</td>			-	0				97.00
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 113.00 INTEREST EXPENSE 0 69, 994, 186 113. 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 69, 994, 186 118. 190.00 19000 G [FT, FLOWER, COFFEE SHOP & CANTEEN 0 24, 901 190. 190.01 19001 SHELBY COUNTY MEDI CAL CENTER 0 0 190. 190.02 19002 SI CK CHI LD CARE 0 0 190. 190.03 PRI VATE DUTY 0 0 190. 190.04 19004 ST. VI NCENT'S STRESS 0 0 190. 190.05 19005 MARKETI NG 489, 263 190. 190. 190.06 19006 MH LI GHTBOUND 0 0 190. 190.07 1-74 CAMPUS 0 840, 623 190. 190.08 19009 INTELLIPLEX DEVELOPMENT 0 108, 100 190. 190.09 19010 MS&M 0 0 190. 190. 190.01 19010 0 0			-	1 856 879				100.00
118.00 SUBTOTALS (SUM OF LINES 1-117) 0 69, 994, 186 118. NONRET MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 24, 901 190. 190.01 19001 SHELBY COUNTY MEDI CAL CENTER 0 0 190. 190.02 19002 SI CK CHI LD CARE 0 0 190. 190.03 19003 PRI VATE DUTY 0 0 190. 190.04 19004 ST. VI NCENT'S STRESS 0 0 190. 190.05 19005 MARKETI NG 0 489, 263 190. 190.06 19006 MH LI GHTBOUND 0 0 190. 190.07 1-74. CAMPUS 0 840, 623 190. 190.08 19008 SOUTHEAST OB 0 190. 190.09 1NTELLI PLEX DEVELOPMENT 0 108, 100 190. 190.01 19001 MS&M 0 0 190. 190.10 19001 MS&M 0	101.00			1,000,017				
NORREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 24, 901 190. 190.01 19001 SHELBY COUNTY MEDICAL CENTER 0 0 190. 190.02 19002 SI CK CHI LD CARE 0 0 190. 190.03 PRI VATE DUTY 0 0 190. 190. 190.04 19004 ST. VI NCENT'S STRESS 0 0 190. 190.05 19005 MARKETI NG 0 489, 263 190. 190. 190.06 19006 MH LI GHTBOUND 0 0 190. 190. 190.07 1-74 CAMPUS 0 840, 623 190. 190. 190.08 19008 SOUTHEAST OB 0 0 190. 190. 190.09 1NTELLI PLEX DEVELOPMENT 0 108, 100 190. 190. 190.10 19001 MS&M								113.00
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 24, 901 190. 190.01 19001 SHELBY COUNTY MEDI CAL CENTER 0 0 190. 190.02 19002 SI CK CHI LD CARE 0 0 190. 190.03 19003 PRI VATE DUTY 0 0 190. 190.04 19004 ST. VI NCENT'S STRESS 0 0 190. 190.05 19005 MARKETI NG 0 489, 263 190. 190.06 19006 MH LI GHTBOUND 0 0 190. 190.07 1-74 CAMPUS 0 840, 623 190. 190.08 19009 INTELLI PLEX DEVELOPMENT 0 108, 100 190. 190.09 19009 INTELLI PLEX DEVELOPMENT 0 0 190. 190.10 19001 MS&M 0 0 190. 190.11 190110 THER NON-REI MBURSEABLE CENTERS 0 0 190. 190.12 19012 BARTLEY ORTHOPEDI CS 0 0 190.	118.00		0	69, 994, 186				118.00
190.01 19001 SHELBY COUNTY MEDI CAL CENTER 0 0 190. 190.02 19002 SI CK CHI LD CARE 0 0 190. 190.03 19003 PRI VATE DUTY 0 0 190. 190.04 19004 ST. VI NCENT'S STRESS 0 0 190. 190.05 19005 MARKETI NG 0 489, 263 190. 190.07 19006 MH LI GHTBOUND 0 0 190. 190.08 19008 SOUTHEAST OB 0 840, 623 190. 190.09 19009 INTELLI PLEX DEVELOPMENT 0 108, 100 190. 190.10 19001 MS&M 0 0 190. 190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 190. 190.12 19012 BARTLEY ORTHOPEDI CS 0 0 190.	190 00		0	24 901				190.00
190.03 PRI VATE DUTY 0 0 190. 190.04 19004 ST. VI NCENT'S STRESS 0 0 190. 190.05 19005 MARKETI NG 0 489, 263 190. 190.07 19006 MH LI GHTBOUND 0 0 190. 190.07 19007 I -74 CAMPUS 0 840, 623 190. 190.08 19008 SOUTHEAST OB 0 0 190. 190.09 19009 INTELLI PLEX DEVELOPMENT 0 108, 100 190. 190.10 19010 MS&M 0 0 190. 190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 190. 190.12 19012 BARTLEY ORTHOPEDI CS 0 0 190.			0	0				190.01
190.04 19004 ST. VINCENT'S STRESS 0 0 190. 190.05 19005 MARKETING 0 489, 263 190. 190.06 19006 MH LIGHTBOUND 0 0 190. 190.07 19007 I -74 CAMPUS 0 840, 623 190. 190.08 19008 SOUTHEAST OB 0 0 190. 190.09 19009 INTELLI PLEX DEVELOPMENT 0 108, 100 190. 190.10 19010 MS&M 0 0 190. 190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 190. 190.12 19012 BARTLEY ORTHOPEDI CS 0 0 190.			0	0				190. 02
190.05 19005 MARKETI NG 0 489, 263 190. 190.06 19006 MH LI GHTBOUND 0 0 190. 190.07 19007 I -74 CAMPUS 0 840, 623 190. 190.08 19008 SOUTHEAST OB 0 0 190. 190.09 19009 INTELLI PLEX DEVELOPMENT 0 108, 100 190. 190.10 19010 MS&M 0 0 190. 190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 190. 190.12 19012 BARTLEY ORTHOPEDI CS 0 0 190.			0	0				190. 03 190. 04
190.06 19006 MH LI GHTBOUND 0 190. 190.07 19007 I -74 CAMPUS 0 840, 623 190. 190.08 19008 SOUTHEAST OB 0 0 190. 190.09 19009 INTELLI PLEX DEVELOPMENT 0 108, 100 190. 190.10 19010 MS&M 0 0 190. 190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 190. 190.12 19012 BARTLEY ORTHOPEDI CS 0 0 190.			0	489, 263				190.04
190.08 19008 SOUTHEAST OB 0 190.0 190.09 19009 INTELLI PLEX DEVELOPMENT 0 108, 100 190.0 190.10 19010 MS&M 0 0 190.0 190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 190.0 190.12 19012 BARTLEY ORTHOPEDI CS 0 0 190.0	190.06	19006 MH LI GHTBOUND	0	0				190. 06
190.09 19009 INTELLI PLEX DEVELOPMENT 0 108, 100 190. 190.10 19010 MS&M 0 0 190. 190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 190. 190.12 19012 BARTLEY ORTHOPEDI CS 0 0 190.			0	840, 623				190.07
190.10 19010 MS&M 0 0 190. 190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 190. 190.12 19012 BARTLEY ORTHOPEDI CS 0 0 190.			0	108 100				190. 08 190. 09
190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 190. 190.12 19012 BARTLEY ORTHOPEDI CS 0 0 190.			0	00, 100				190.09
	190.11	19011 OTHER NON-REIMBURSEABLE CENTERS	Ō	ō				190. 11
190. 13/19013/SSA 0 0 1190.			0	0				190. 12 190. 13

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150097	Peri od:	Worksheet B	
				From 01/01/2015 To 12/31/2015	Part I Date/Time Pre	pared:
					4/28/2016 3:2	
Cost Center Description	Intern &	Total				
	Residents Cost					
	& Post					
	Stepdown					
	Adjustments					
	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 I MA	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 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
192. 01 19201 HOSPI TALI ST	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

	Financial Systems TION OF CAPITAL RELATED COSTS	MAJOR HO		F	eriod: rom 01/01/2015	w of Form CMS-2 Worksheet B Part II	
				T	b 12/31/2015	Date/Time Pre 4/28/2016 3:2	
	Cost Center Description	Directly Assigned New Capital	CAPI TAL <u>RELATED COSTS</u> BLDG & FI XT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	COMMUNI CATI ONS	
		Related Costs 0	1.00	2A	4.00	5. 01	
1 00	GENERAL SERVICE COST CENTERS			1			1 00
1.00 4.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	0	10, 643	10, 643	10, 643		1.00 4.00
5.01	01160 COMMUNI CATI ONS	0	5, 735	5, 735	4	5, 739	5.01
5.02	00550 DATA PROCESSING	0	13, 363		316		5.02
5.03 5.04	00590 PURCHASING, RECEIVING, AND STORES 00570 ADMITTING	0	14, 368 31, 889		61 261	87	5.03 5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	0	147	0	5.05
5.06	00592 OTHER ADMINISTRATIVE AND GENERAL	0	209, 173		1, 126	444	5.06
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	222, 989 10, 939		218 9	0	7.00 8.00
9.00	00900 HOUSEKEEPI NG	0	5, 065		209	43	
10.00	01000 DI ETARY	0	48, 524		46		
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	76, 846 33, 170		104 299	0 401	11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	62, 695		0	54	14.00
15.00	01500 PHARMACY	0	28, 539		232	97	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	43, 419	43, 419	220	173	16.00
30. 00	03000 ADULTS & PEDIATRICS	0	478, 400	478, 400	1, 488	823	30.00
31.00	03100 INTENSIVE CARE UNIT	0	146, 498		292	206	1
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0	0	0		
42.00	ANCI LLARY SERVICE COST CENTERS	0	0	<u>ı</u> 0	0	0	42.00
50.00	05000 OPERATING ROOM	0	191, 928		808		50.00
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0 9, 283	0 9, 283	0 676	0	52.00 53.00
53.00 54.00	05400 RADI OLOGY - DI AGNOSTI C	0	183, 157	183, 157	570		
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
56. 01 57. 00	05601 ONCOLOGY 05700 CT SCAN	0	327, 527 7, 884	327, 527 7, 884	305 86		56.01 57.00
57.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	7, 884	0	84	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	39, 517	39, 517	499 0	238	60.00 60.01
65.00	06500 RESPIRATORY THERAPY	0	16, 477	16, 477	218		
65.01	06501 SLEEP LAB	0	0	0	109	43	1
66.00	06600 PHYSI CAL THERAPY	0	12, 417	12, 417	392	260	
69.00 71.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	55, 639 0		130 14		
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	11		
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	73.00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
	08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0	0	0		89.00
90.00 91.00	09000 CLINIC 09100 EMERGENCY	0	98, 487		63 647	184	90.00 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	104, 478	104, 478 0	047	221	91.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
	10100 HOME HEALTH AGENCY	0	0	0	210		101.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE			1		[113.00
118.00		0	2, 489, 049	2, 489, 049	9, 854	5, 566	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7, 332	7, 332	0		190.00
	19001 SHELBY COUNTY MEDICAL CENTER 19002 SICK CHILD CARE	0	0	0	0		190. 01 190. 02
	19003 PRI VATE DUTY	0	0	0	0		190.02
190.04	19004 ST. VINCENT'S STRESS	0	0	0	0	0	190. 04
	19005 MARKETI NG 19006 MH LI GHTBOUND	0	3, 784	3, 784	58 0		190. 05 190. 06
	19007 I -74 CAMPUS	0	0	0	40		190.08
190.08	19008 SOUTHEAST OB	0	0	0	0	0	190. 08
	19009 INTELLIPLEX DEVELOPMENT 19010 MS&M	0	0	0	3		190. 09 190. 10
	19010 MS&M 19011 OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0		190. 10 190. 11
	19012 BARTLEY ORTHOPEDI CS	0	0	0	0		190. 12

Health Financial Systems	MAJOR HC	SPI TAL		In Lie	eu of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2015	Worksheet B Part II	
				To 12/31/2015		pared:
		CAPI TAL			4/28/2016 3:2	
		RELATED COSTS				
Cost Center Description	Di rectl y	BLDG & FIXT	Subtotal	EMPLOYEE	COMMUNI CATI ONS	
	Assigned New			BENEFI TS		
	Capi tal			DEPARTMENT		
	Related Costs					
	0	1.00	2A	4.00	5. 01	
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 1	0	190. 16
190. 17 19017 IMA	0	0		0 0		190. 17
190. 18 19018 MD SOLUTI ONS	0	0		0 0	0	190. 18
190. 19 19019 MHCD	0	5, 203	5, 20	3 0	0	190. 19
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
192. 01 19201 HOSPI TALI ST	0	0)	0 509	11	192. 01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	50, 278	50, 27	8 178	162	194.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0)	0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	2, 555, 646	2, 555, 64	6 10, 643	5, 739	202.00

ALLOCATION OF CAPITAL RELATED COSTS Provide Cost: 50007 Private: In the Cost Content bioscription Provide Cost: 50007 Private: In the Cost Cost Content bioscription Provide Cost: 50007 Private: First Status Private: First Status Private: First Status		Financial Systems	MAJOR H		CON 150007 D		u of Form CMS-	2552-10
Cost Center Description DATA PROCESSING ADMITTING CASI ITEN VACUUE Montest Stream 100 COTTOQUE REL_COSTS AUDIA FIXTU 9.02 5.03 5.04 5.04 5.04 100 COTTOQUE REL_COSTS AUDIA FIXTU 1 0 5.04 5.04 5.04 5.04 5.04 5.04 5.04 5.04 5.04 5.04 5.04 5.01 <	ALLUCA	ITION OF CAPITAL RELATED COSTS		Provi der	F	rom 01/01/2015	Part II Date/Time Pre	pared:
BREAM SQUITE COULD		Cost Center Description		RECEIVING, AND		OUNTS	OTHER ADMI NI STRATI VE	
1.00 DOUGL GAP FIEL COSTS-BLUE & FIXI 4.00 4.00 DOUGL GAP FIEL COSTS-BLUE & FIXI 4.00 5.00 DUDATA FILL COSTS-BLUE & FIXI 4.00 5.00 DUDATA FILL COSTS-BLUE & FIXI 5.00 5.01 DUDATA FILL COSTS ALL CONTRES 7.0 5.00 DUDATA FILL COSTS ALL CONTRES 7.0 5.00 DUDATA FILL CONTRES 7.0 5.00 DUDATA FILL CONTRES 7.0 5.00 DUDATA FILL CONTRES 7.0 5.01 DUDATA FILL FILL FILL FILL FILL FILL FILL FIL			5.02		5.04			
0.00 DOUDD DUPLOVE. BLENH ITS BLEWARKENI 0.00			1					
5. 01 01140 COMMANIL CAT NOS 13. 960 14. 567 33. 240 5. 03 5. 03 00500 PRICALES INC. RECELVING. AND STORES 77 714, 568 33. 240 5. 03 5. 03 00500 PRICALES INC. RECELVING. AND STORES 77 714, 568 33. 240 5. 03 5. 00 00500 PRICALES INC. RECELVING. 33. 240 0 0. 47.44 5. 06 5. 00 00500 PRICALES INC. RECELVING. 32. 241 0 0 0. 47.44 5. 06 6. 00 000000 PRISSING INC. RECELVING. 32. 240 0 0 47.44 0. 00 6. 00 000000 PRISSING INC. RECELVING. 32. 240 0 0 47.44 0. 00 10. 00000 PRISSING INC. RECELVING. 32. 240 0 0 17.46 0 0 17.46 0 0 17.46 0 0 17.46 17.57 14.00 17.66 17.57 14.00 17.66 17.57 14.67 17.57 14.6								
b. 20 000500 DATA PROCESSING 13, 950 33, 240 5, 64 5, 65 5 000570 ADUITTING 20000 PROVENING, RECEIVING, AND STORES 700 117, 580 33, 240 6, 67 5 000570 ADUITTING 20000 PROVENING, RECEIVING, AND STORESAL 1, 174 247 0 0 7, 70 5 00000 PROVENING, RECEIVING, AND STORESAL 1, 174 247 0 0 7, 70 0 0 7, 71 8, 00 6 00000 PROVENING, RECEIVING 434 238 0 0 7, 71 8, 00 7, 71 8, 00 7, 71 8, 00 7, 71 8, 00 7, 71 8, 00 7, 71 8, 00 7, 71 8, 00 7, 71 8, 00 7, 72 1, 11, 11 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
5.03 000509 PURCHASING, RECELVING, AND STORES 700 1.4, 680			13, 950					
5.05 000500 CASHE ER INVACCOUNTS RECEIVABLE 399 106 0 6-64 1.1 5.05 0.0000 DEPAIL TO YIE AND INVECT 2.24 2.0 0 0 0.0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
5.06 DOSPO [THER ADDINISTIGATION ADDINING 1,174 247 0 0 77.16 5.00 8.00 DOSSOL LARGEY & LINER SERVICE 22 0 0 0 77.16 5.00 8.00 DOSSOL LARGEY & LINER SERVICE 22 0 0 0 0 0 77.16 5.00 77.16 5.00 77.16 5.00 77.16 5.00 77.16 5.00 77.16 5.00 77.16 5.00 77.16 5.00 77.16 5.00 77.16 5.00 77.16 5.00 77.16 5.00 77.16 5.00 77.16 5.00 77.16 7.00 </td <td></td> <td></td> <td></td> <td></td> <td>33, 240</td> <td></td> <td></td> <td></td>					33, 240			
7.00 00700 DEFEATING FERDING 352 18 0 0 8.040 7.00 0 7.01 0.00 7.02 0.00 7.02 0.00 7.01 7.00 0.00 7.01 7.00 0.00 7.01 0.00 0.00 7.01 7.00 7.01 7.00 7.01 7.01 7.01 7.01 7.01 7.01 7.01 7.01 7.01 7.01 7.01 7.01 7.01					-			
8.00 00800 JUNIDEY & LINEN SERVICE 23 0 0 7737 8.00 9.00 00000 10.00 10.00 10.00 0 1.320 10.00 10.00 00000 11.183 10.00 10.00 11.183 10.00 11.00 10.00 11.184 11.183 10.00 10.00 11.230 11.00 14.00 0.1400 ENEW ICS & SUPPLY 72 46.0 0 17.23 13.00 15.00 01500 HEART ROUTINE SCRUICE COST CENTERS -						-		1
9.00 0000 MUSE CEPN NG 6 434 228 0 0 4.774 9.00 1.326 10.00 1.326						-		1
10. 00 01000 DETAY 446 130 0 0 1.320 10. 00 11.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td>						-		
13.00 13.00 13.00 13.00 4, 762 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 16.00 10.00 10.025 15.00 10.00 10.025 15.00 10.025 10.00 10.025 10.00	10.00	01000 DI ETARY	446	130	0	0	1, 320	10.00
14 00 0 1400 CENT SERVICE AS LIBRARY 70 467 0 0 222 14 00 16 00 DIGO (FRICAL) RECORDS & LIBRARY 399 64 0 4,348 16 00 IBRATTER GUITE SERVICE COST CENTERS 2,166 1,812 1,928 45 27,002 30.00 IBRATTER GUITE SERVICE COST CENTERS 0 <td></td> <td></td> <td>-</td> <td>-</td> <td></td> <td>-</td> <td></td> <td></td>			-	-		-		
15.00 0 ISDD (PHABMACY 258 150 0 0 19.025 15.00 IMPATERNT ROUTINE SERVICE CORDS & LIBRARY 399 64 0 0 0.00						-		1
16. 00 0 0 0 4 0 4 34 0 0 4 34 10 0 0. 00 00000 AULTS REVICE COST CENTERS 1 1 0						-		1
INPART LENT BOUTINE SERVICE COST CENTERS Impact Lent BOUTINE SERVICE COST CENTERS 0.00 0.3100 NUTS & FEDATORY 2,166 1,923 45 27,002 30.00 11.00 0.100 0.3100 INTERS VE CARE UNIT 4.446 885 4.88 11 5,708 31.00 0.100 0.3100 INTERS VE CARE UNIT 4.446 885 4.88 11 5,708 31.00 4.400 0<						-		1
11 00 03100 MTERSIVE CARE UNIT 1446 6355 488 11 5,978 31.00 11 00 01000 LUBPROVIDER 0							.,	
41.00 04100 SUPPRVIDER - I PF 0 <th< td=""><td>30.00</td><td></td><td>2, 166</td><td>1, 812</td><td>1, 928</td><td>45</td><td>27, 002</td><td>30.00</td></th<>	30.00		2, 166	1, 812	1, 928	45	27, 002	30.00
42.00 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
ANCI LARY SERVICE COST CONTERS - 0.00 05000 (DELATIN & ROAM 966 3,74 4,399 102 17,051 50.00 52.00 05200 (DELIVERY ROAM & LABOR ROAM 0 0 0 0 0 0 52.00 53.00 05300 (RADIOLOGY) 1646 647 15,77 4 467 55.00 0								
50. 00 65000 (DELEVERY ROM & LABOR ROM 996 3. 7.43 4. 389 102 117, 05 50. 00 53. 00 05300 (DELVERY ROM & LABOR ROM 0 0 0 0 52. 00 54. 00 05400 (ANDSTIC) 798 346 2. 860 67 15, 37 4 44. 67 53. 00 56. 00 05600 (RADI 0STOPE 0 0 0 0 0 56. 00 56. 00 06500 (RADI OSC) (MCCLORY 423 449 1, 424 33 7, 986 56. 01 56. 00 56. 00 56. 00 56. 00 56. 00 0 0 0 0 57. 00 00 0 0 0 0 59. 00 00 0 0 0 0 0 0 65. 00 59. 00 0 0 0 0 0 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00	42.00			<u> </u>	0	0	0	42.00
53. 00 05300 AMESTHESI OLGOY 164 649 157 4 4.467 53. 00 54. 00 05600 05600 RADI OLSOTOPE 0	50.00		986	3, 743	4, 389	102	17,051	50.00
54.00 05400 RADIOLOGY-LI AGNOSTIC 798 346 2.8co 67 15.71 54.00 56.01 05001 ONCOLOGY 423 449 1.424 33 7.986 56.01 55.00 05600 CT SCAN 70 163 2.629 61 3.777 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 94 7 1.278 30 2.664 80.00 0.00 0 <td>52.00</td> <td>05200 DELIVERY ROOM & LABOR ROOM</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>52.00</td>	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
56.00 OSEGO RADI ISOTOPE O O O D 56.00 S6.00 S6						4		
56 01 05601 0NCOLCOY 423 449 1, 424 33 7, 968 57, 00 57,00 05700 00 0								
57.00 05700 CT SCAN 70 16.3 2.629 61 3.277 57.00 58.00 05500 CABOM ACC CATHETER LATION 0 </td <td></td> <td></td> <td></td> <td>-</td> <td>-</td> <td>-</td> <td></td> <td></td>				-	-	-		
58:00 OSB00 MACHTIC RESONANCE LINGING (MRI) 94 78 1,278 30 2,664 58:00 59:00 OSB00 CARDIAC CATHETERIZATION 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
99 00 0								
60.01 0 <td>59.00</td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>	59.00		0	0				
65:00 0c500 RESP IRATORY THERAPY 258 214 494 11 3,909 65:00 66:01 0c600 PHYSI CAL THERAPY 470 238 845 20 7,480 66:00 69:00 09900 ELECTROCARDIOLOGY 235 315 706 16 2.641 69:00 71:00 MCDICAL SUPPLIES CHARGED TO PATIENTS 70 0 1.218 28 5.077 70:00 7.200 1.2018 28 5.077 70:00 7.0							16, 861	
65.01 06501 SLEEP LAB 141 130 525 12 2,320 65.01 66.00 069000 FLECTROCARDIOLOCY 235 315 706 16 2,440 66.00 71.00 0710.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 70 0 1,218 28 5,087 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 3,032 71 906 0073.00 073000 DRUGS CHARGED TO PATIENTS 0 0 3,032 71 906 90.00 08000 RURAL HEALTH CLINIC 0 0 0 0 88.00 90.00 090000 FEDERALLY OUALIFIED HEALTH CENTER 0 0 0 0 0 88.00 91.00 090000 FEDERALY OUALIFIED HEALTH CENTER 94 4.8 2.9 1 66.0 90.00 92.00 095000 AURBLANCE SERVICY 845 1,419 5,343 5 14.211 91.00 92.00 95.00 095000 AURBLANCE SERVICY <			-		-	-		
66:00 OG6000 PHYSICAL THERAPY 470 238 845 20 7.460 66.00 66.00 66:00 00 000 ELECTROCARDIOLOCY 235 315 706 16 2.41 69.00 71.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.								
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73.00 DATE ON TOTAL LEAST D 3,032 71 906 73.00 0UTPATI ENT SERVICE COST CENTERS 0<								
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0								
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95.00 O9500 AMBULANCE SERVI CES 0 <td>92.00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>92.00</td>	92.00							92.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0	95.00		(0	0	0	0	95.00
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113.00 113.00 INTEREST EXPENSE 113.00 110.00 0 0 0 0 0 0 0 0 0 190.01 190.02 190.03 190.03 190.04 190.04 190.04 190.04 190.05 190.05 190.05 190.05 190.05 190.05 190.	101.00		282	292	281	7	4, 838	101.00
118.00 SUBTOTALS (SUM OF LINES 1-117) 13,340 14,057 33,240 654 193,211 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 23 190.00 190.01 19001 SHELBY COUNTY MEDI CAL CENTER 0 0 0 0 190.01 190.02 19002 SI CK CHI LD CARE 0 0 0 0 190.02 190.03 19003 PRI VATE DUTY 0 0 0 0 190.03 190.04 19004 ST. VI NCENT'S STRESS 0 0 0 190.04 190.05 19005 MARKETI NG 477 0 0 190.06 190.06 190.06 19006 H LI GHTBOUND 0 0 0 190.07 190.07 190.07 19007 I-74 CAMPUS 117 2 0 0 190.08 190.09 19009 INTELLI PLEX DEVELOPMENT 0	112 00		1					112 00
NORREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 23 190.00 190.01 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.01 190.02 19002 SI CK CHI LD CAL CENTER 0 <td></td> <td></td> <td>13 340</td> <td>14 057</td> <td>33 240</td> <td>654</td> <td>193 211</td> <td></td>			13 340	14 057	33 240	654	193 211	
190.01 19001 SHELBY COUNTY MEDI CAL CENTER 0 0 0 190.01 190.02 19002 SI CK CHI LD CARE 0 0 0 0 190.02 190.03 19003 PRI VATE DUTY 0 0 0 0 190.03 190.04 19004 ST. VI NCENT'S STRESS 0 0 0 190.04 190.05 MARKETI NG 47 0 0 0 190.05 190.07 19006 MARKETI NG 0 0 0 190.06 190.07 19007 I-74 CAMPUS 117 2 0 0 190.08 190.09 INTELLI PLEX DEVELOPMENT 0 0 0 0 190.09 190.09 19009 INTELLI PLEX DEVELOPMENT 0 0 0 190.09 190.11 19010 MS&M 0 0 0 0 190.10 190.12 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 0 0 190.11 190.12 19012 BARTLEY ORTHOPEDI CS	110.00		10,010	11,007	00,210	001	170,211	110.00
190.02 19002 SI CK CHI LD CARE 0 0 0 190.02 190.03 19003 PRI VATE DUTY 0 0 0 0 190.03 190.04 19004 ST. VI NCENT'S STRESS 0 0 0 0 190.04 190.05 19005 MARKETI NG 47 0 0 0 190.05 190.06 19006 MH LI GHTBOUND 0 0 0 190.06 190.07 190.07 19007 I -74 CAMPUS 117 2 0 0 190.08 190.09 INTELLI PLEX DEVELOPMENT 0 0 0 0 190.09 190.09 19009 INTELLI PLEX DEVELOPMENT 0 0 0 190.09 190.10 19010 MS&M 0 0 0 0 190.01 190.11 19010 MS&M 0 0 0 0 190.01 190.12 19011 OTHEAST OB 0 0 0 0 190.02 190.11 19010 MS&	190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0 0	0	0	23	190. 00
190.03 PRI VATE DUTY 0 0 0 190.03 190.04 19004 ST. VI NCENT'S STRESS 0 0 0 0 190.04 190.05 19005 MARKETI NG 47 0 0 0 190.05 190.06 19006 MH LI GHTBOUND 0 0 0 0 190.06 190.07 19007 I -74 CAMPUS 117 2 0 0 190.08 190.09 INTELLI PLEX DEVELOPMENT 0 0 0 0 190.09 190.01 19010 MS&M 0 0 0 0 190.09 190.09 INTELLI PLEX DEVELOPMENT 0 0 0 0 190.09 190.10 19010 MS&M 0 0 0 0 190.09 190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 0 0 190.11 190.12 JARTLEY ORTHOPEDI CS 0 0 0 0 190.12 190.12 190.14 19014 SPORTSW			0	0 0	0	0		
190.04 19004 ST. VINCENT'S STRESS 0 0 0 190.04 190.05 19005 MARKETING 47 0 0 1, 304 190.05 190.06 19006 MH LIGHTBOUND 0 0 0 0 190.06 190.07 19007 I-74 CAMPUS 117 2 0 0 190.08 190.09 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 0 190.09 190.11 19010 MS&M 0 0 0 190.10 190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 0 190.10 190.12 19012 BARTLEY ORTHOPEDI CS 0 0 0 190.12 190.13 19013 SSA 0 0 0 0 190.13 190.14 19014 SPORTSWORKS 0 <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>				0	0	0		
190.05MARKETI NG470001, 304190.05190.0619006MH LI GHTBOUND0000190.06190.0719007I -74 CAMPUS1172002, 198190.07190.0819008SOUTHEAST OB0000190.08190.08190.0919009INTELLI PLEX DEVELOPMENT000289190.09190.1019010MS&M000190.10190.1119011OTHER NON-REI MBURSEABLE CENTERS000190.12190.12BARTLEY ORTHOPEDI CS0000190.13190.1419014SPORTSWORKS0000190.13						0		
190.06 19006 MH LIGHTBOUND 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 0 190.08 190.09 19009 INTELLI PLEX DEVELOPMENT 0 0 0 289 190.09 190.10 19010 MS&M 0 0 0 0 190.10 190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 0 190.11 190.12 19012 BARTLEY ORTHOPEDI CS 0 0 0 0 190.12 190.14 19014 SPORTSWORKS 0 0 0 0 190.13			47	0	0	0		
190.08 SOUTHEAST OB 0 0 0 190.08 190.09 19009 INTELLI PLEX DEVELOPMENT 0 0 0 289 190.09 190.10 19010 MS&M 0 0 0 0 190.10 190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 0 0 190.11 190.12 JARTLEY ORTHOPEDI CS 0 0 0 190.12 190.12 190.13 19013 SSA 0 0 0 0 190.13 190.14 19014 SPORTSWORKS 0 0 0 0 190.14			C	0	0	0		
190.0919009INTELLI PLEX DEVELOPMENT000289190.09190.1019010MS&M0000190.10190.1119011OTHER NON-REI MBURSEABLE CENTERS0000190.11190.1219012BARTLEY ORTHOPEDI CS0000190.12190.1319013SSA0000190.13190.1419014SPORTSWORKS0000190.14			117	2	0	0		
190.1019010MS&M000190.10190.1119011OTHER NON-REI MBURSEABLE CENTERS0000190.11190.1219012BARTLEY ORTHOPEDI CS0000190.12190.1319013SSA00000190.13190.1419014SPORTSWORKS00000190.14			0	0	0	0		
190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 0 190.11 190.12 19012 BARTLEY ORTHOPEDI CS 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				0	0	0		
190.12 19012 BARTLEY ORTHOPEDI CS 0 0 0 0 190.12 190.13 19013 SSA 0 0 0 0 190.13 190.14 19014 SPORTSWORKS 0 0 0 0 0 190.14	190.10	19011 OTHER NON-RELMBURSEARLE CENTERS				0		
190.13 19013 SSA 0 0 0 0 190.13 190.14 19014 SPORTSWORKS 0 0 0 0 190.14				0	0	0		
	190.13	19013 SSA	0	o o	0	0	0	190. 13
190. 15 19015 SHELBY PEDS 0 0 0 0 190. 15			0	0		-		
	190.15	I 19015 SHELBY PEDS	(ין 0	0	0	0	190.15

Health Financial Systems	MAJOR HC	SPI TAL		In Lie	eu of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period:	Worksheet B	
				From 01/01/2015 To 12/31/2015		nared
				10 12/01/2010	4/28/2016 3:2	
Cost Center Description	DATA	PURCHASI NG,	ADMI TTI NG	CASHI ERI NG/ACC	OTHER	
	PROCESSI NG	RECEIVING, AND		OUNTS	ADMI NI STRATI VE	
		STORES		RECEI VABLE	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 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	0		0 0	3, 939	190. 19
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
192. 01 19201 HOSPI TALI ST	211	0		0 0	7, 695	192.01
194.0007950 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		o o	0	201.00
202.00 TOTAL (sum lines 118-201)	13, 950	14, 586	33, 24	0 654	212, 164	202.00

	Financial Systems	MAJOR HO		CON 150007		u of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der	F	eriod: rom 01/01/2015 o 12/31/2015	Worksheet B Part II Date/Time Pre 4/28/2016 3:2	pared:
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	CAFETERI A	
		7.00	8.00	9.00	10.00	11.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 5.02	01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG						5. 01 5. 02
5.02 5.03	00550 DATA PROCESSING 00590 PURCHASING, RECEIVING, AND STORES						5.02
5.04	00570 ADMI TTI NG						5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5.06 7.00	00592 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	221 417					5.06 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	231, 617	12, 945				8.00
9.00	00900 HOUSEKEEPI NG	573	0				9.00
10.00	01000 DI ETARY	5, 489	0	274			10.00
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	8, 693 3, 752		434 187		87, 817 3, 170	
14.00	01400 CENTRAL SERVICES & SUPPLY	7,092	0	354		3, 170	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
30.00	03000 ADULTS & PEDIATRICS	54, 119	4, 998	2, 701	50, 467	19, 973	30.00
31.00	03100 I NTENSI VE CARE UNI T	16, 572			5, 870	4, 134	31.00
41.00	04100 SUBPROVI DER – I RF	0	0			0	41.00
42.00	04200 SUBPROVI DER ANCI LLARY SERVI CE COST CENTERS	0	0	C	0	0	42.00
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	52.00
53.00	05300 ANESTHESI OLOGY	1,050				1, 993	53.00
54.00 56.00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	20, 719	1, 572 0		0	6, 504 0	54.00 56.00
56.01	05601 ONCOLOGY	37, 051	0	-	0	3, 831	56.01
57.00	05700 CT SCAN	892	0			1, 221	57.00
58.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	0	-	-	1, 080	
59.00 60.00	06000 LABORATORY	4, 470	361		-	0 8, 617	59.00 60.00
60.01	06001 BLOOD LABORATORY	0	0			0	60.01
65.00	06500 RESPI RATORY THERAPY	1, 864	0			2, 445	
65. 01 66. 00	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	0 1, 405	0 510	, i i i i i i i i i i i i i i i i i i i		0 4, 454	65.01 66.00
69.00	06900 ELECTROCARDI OLOGY	6, 294	125		-	1, 927	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	370	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	296	1
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0		0	0	73.00
88.00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	0	
90. 00 91. 00	09000 CLINIC 09100 EMERGENCY	11, 141				907 8, 194	90.00 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	11,017	2,747	570		0, 174	92.00
	OTHER REIMBURSABLE COST CENTERS		I	1			
	09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	, °	0	0	
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0		100.00
	10100 HOME HEALTH AGENCY	0	0	C	0		101.00
112 00	SPECIAL PURPOSE COST CENTERS			1	I		112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	224, 083	12, 941	11, 091	56, 337	84 180	113.00 118.00
	NONREI MBURSABLE COST CENTERS	2217000				01,100	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	829			0		190.00
	19001 SHELBY COUNTY MEDICAL CENTER 219002 SICK CHILD CARE	0	0	0	0		190. 01 190. 02
	19002 STOK CHTED CARE	0	0		0		190.02
190. 04	19004 ST. VINCENT'S STRESS	0	0	C	0	0	190. 04
	19005 MARKETI NG	428	0	21	0		190.05
	5 19006 MH LIGHTBOUND 7 19007 I - 74 CAMPUS	0			0		190. 06 190. 07
	19007 1-74 CAMPUS 3 19008 SOUTHEAST OB	0	0	c c	0		190.07
190.09	19009 INTELLIPLEX DEVELOPMENT	0	0	C	0		190. 09
	19010 MS&M	0	0		0		190. 10 190. 11
	19011 OTHER NON-REI MBURSEABLE CENTERS 19012 BARTLEY ORTHOPEDICS	0			0		190. 11
	3 19013 SSA	0	0	d d	0		190.12
	19014 SPORTSWORKS	0	0	C	0		190.14
	19015 SHELBY PEDS 19016 RENOVO	0			0		190. 15 190. 16
170.10		0	ı 0	1 U	I U	0	170.10

Health Financial Systems	MAJOR HOSPI TAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B		
				From 01/01/2015 To 12/31/2015		parad.	
				10 12/31/2015	4/28/2016 3:2		
Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NO	G DI ETARY	CAFETERI A		
	PLANT	LINEN SERVICE					
	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 SOLUTI ONS	0	0		0 0	0	190. 18	
190. 19 19019 MHCD	589	0	4	29 0	0	190. 19	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00	
192. 01 19201 HOSPI TALI ST	0	0		0 0	1, 892	192.01	
194.00079500THER NONREIMBURSABLE COST CENTERS	5, 688	4	28	34 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, 46	56, 337	87, 817	202.00	

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Pre	
Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	<u>4/28/2016 3:2</u> Subtotal	<u>Opm</u>
	13.00	14.00	15.00	16. 00	24.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT				I		1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 01160 COMMUNI CATI ONS						5. 01
5. 02 00550 DATA PROCESSI NG						5.02
5. 03 00590 PURCHASING, RECEIVING, AND STORES 5. 04 00570 ADMITTING						5.03 5.04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04
5. 06 00592 OTHER ADMINI STRATI VE AND GENERAL						5.06
7.00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8.00 9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
13. 00 01300 NURSING ADMINISTRATION	46, 368	74.004				13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0	71, 024 0	54, 70	14		14.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	54,70	0 57, 492		16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	14,974	0		0 3, 932	664, 828	•
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF	3, 100 0	0		0 775 0 0	186, 809 0	•
42. 00 04200 SUBPROVI DER	0	0		0 0	0	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	6, 701	0		0 7,485 0 0	267, 260	•
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	1, 494	0		0 267	0 20, 304	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 4,878	238, 136	•
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
56. 01 05601 0NC0L0GY	2,872	0		0 2,428	386, 709	1
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 4, 483 0 2, 179	20, 810 7, 487	57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
60. 00 06000 LABORATORY	0	0		0 7, 865	85, 760	1
60. 01 06001 BLOOD LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY 65. 01 06501 SLEEP LAB	1, 833 1, 056	0		0 843 0 895	29, 006 5, 231	65.00 65.01
66.00 06600 PHYSI CAL THERAPY	0	0		0 1,442	30, 003	
69.00 06900 ELECTROCARDI OLOGY	1, 445	0		0 1, 205	70, 992	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	ITS 0 0	39, 063 31, 961		0 2, 077 0 1, 709	47, 927 39, 896	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0			63, 884	
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0 680	0		0 49	0 112, 944	89.00 90.00
91. 00 09100 EMERGENCY	6, 143	0		0 9, 329	165, 999	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	T)					92.00
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES	0	0	1	0 0	0	95.00
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		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			1			113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	42, 328	71, 024	54, 70	57, 492	2, 452, 405	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEE	N O	0		0 0		190.00
190. 01 19001 SHELBY COUNTY MEDI CAL CENTER 190. 02 19002 SI CK CHI LD CARE	0	0		0 0		190. 01 190. 02
190. 03 19003 PRI VATE DUTY	0	0		0 0		190.02
190. 04 19004 ST. VINCENT' S STRESS	0	0		0 0		190. 04
190. 05 19005 MARKETI NG	0	0		0 0		190.05
190. 06 19006 MH_LIGHTBOUND 190. 07 19007 I-74_CAMPUS	772	0				190. 06 190. 07
190. 08 19008 SOUTHEAST OB	0	0		0 0		190.08
190. 09 19009 I NTELLI PLEX DEVELOPMENT	54	0		0 0		190. 09
190. 10 19010 MS&M	0	0	1	0 0		190. 10 190. 11
190. 11 19011 OTHER NON-REI MBURSEABLE CENTERS 190. 12 19012 BARTLEY ORTHOPEDI CS	0	0		0 0		190.11
190. 13 19013 SSA	0	0		0 0		190. 12
190. 14 19014 SPORTSWORKS	0	0		0 0		190.14
190. 15 19015 SHELBY PEDS	0	0	1	<u>vj</u> 0	0	190. 15

Health Financial Systems	MAJOR HOSPI TAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150097	Period: From 01/01/2015	Worksheet B Part		
				To 12/31/2015	Date/Time Pre		
			BUILDING		4/28/2016 3:2	0 pm	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal		
	ADMI NI STRATI ON	SERVICES &		RECORDS &			
		SUPPLY		LI BRARY			
	13.00	14.00	15.00	16.00	24.00		
190. 16 19016 RENOVO	0	0		0 0	150	190. 16	
190. 17 19017 I MA	0	0		0 0	0	190. 17	
190. 18 19018 MD SOLUTI ONS	0	0		0 0	0	190. 18	
190. 19 19019 MHCD	0	0		0 0	9, 760	190. 19	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00	
192. 01 19201 HOSPI TALI ST	1, 419	0		0 0	11, 737	192.01	
194.0007950 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, 70	57, 492	2, 555, 646	202.00	

	Financial Systems TION OF CAPITAL RELATED COSTS	MAJOR HOSE		CCN: 150097	Period: From 01/01/2015	u of Form CMS-2552-10 Worksheet B Part II Date/Time Prepared: 4/28/2014 2:20 pm
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total 26.00		1	4/28/2016 3:20 pm
	GENERAL SERVICE COST CENTERS	20.00	20.00			
1.00 4.00 5.01 5.02 5.03 5.04 5.05 5.06	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG 00590 PURCHASI NG, RECEI VI NG, AND STORES 00570 ADMITTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00592 OTHER ADMINI STRATI VE AND GENERAL					1.00 4.00 5.01 5.02 5.03 5.04 5.05 5.06
7.00 8.00 9.00 10.00 11.00 13.00	00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY					3.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00
15.00	01500 PHARMACY 01600 MEDI CAL_RECORDS & LI BRARY					14.00 15.00 16.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	664, 828			30.00
31. 00 41. 00	03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER	0	186, 809 0			30.00 31.00 41.00 42.00
	ANCI LLARY SERVI CE COST CENTERS					
52. 00 53. 00	05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0 0 0	267, 260 0 20, 304			50. 00 52. 00 53. 00
54.00 56.00 56.01	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE 05601 ONCOLOGY	0 0 0	238, 136 0 386, 709			54. 00 56. 00 56. 01
57.00 58.00 59.00 60.00	05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 0 0 0	20, 810 7, 487 0 85, 760			57. 00 58. 00 59. 00 60. 00
65. 00 65. 01	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY 06501 SLEEP LAB	0 0 0	0 29, 006 5, 231			60. 01 65. 00 65. 01
71.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0 0	30, 003 70, 992 47, 927			66.00 69.00 71.00
73.00	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS DUTPATIENT SERVICE COST CENTERS	00	39, 896 63, 884			72. 00 73. 00
89.00 90.00 91.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0 0	0 0 112, 944 165, 999			88.00 89.00 90.00 91.00 92.00
97.00	OTHER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES 09700 DURABLE MEDI CAL EQUI P-SOLD 10000 I &R SERVI CES-NOT APPRVD PRGM	0 0	0			95. 00 97. 00 100. 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	8, 420			100.00
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	0	2, 452, 405			113. 00 118. 00
190. 01 190. 02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 SHELBY COUNTY MEDICAL CENTER 19002 SICK CHILD CARE 19003 PRIVATE DUTY	0 0 0	8, 225 0 0 0			190. 00 190. 01 190. 02 190. 03
190. 04 190. 05 190. 06	19004 ST. VINCENT'S STRESS 19005 MARKETING 19006 MH LIGHTBOUND 19007 I -74 CAMPUS	0	0 6, 285 0 4, 158			190. 04 190. 05 190. 06 190. 07
190. 08 190. 09 190. 10	19008 SOUTHEAST OB 19009 I NTELLI PLEX DEVELOPMENT 19010 MS&M	0000	4, 138 0 419 0			190. 08 190. 09 190. 10
190.12	19011 OTHER NON-REI MBURSEABLE CENTERS 19012 BARTLEY ORTHOPEDI CS 19013 SSA	0 0 0	0 0 0			190. 11 190. 12 190. 13

Health Financial Systems	MAJOR HOS	MAJOR HOSPITAL			In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150097	Period: From 01/01/2015 To 12/31/2015			
				10 12/31/2013	4/28/2016 3:20 pm		
Cost Center Description	Intern &	Total					
	Residents Cost						
	& Post						
	Stepdown						
	Adjustments						
	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 I MA	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 HOSPI TALI ST	0	11, 737			192.01		
194.0007950 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)		2, 555, 646			202.00		

	Financial Systems LOCATION - STATISTICAL BASIS	MAJOR HO		CCN: 150097 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	
				F	rom 01/01/2015 o 12/31/2015	Date/Time Pre	pared:
		CAPI TAL				4/28/2016 3:2	0 pm
	Cost Conton Description	RELATED COSTS BLDG & FLXT			DATA		
	Cost Center Description	(SQUARE FEET)	EMPLOYEE BENEFI TS	COMMUNI CATI ONS	DATA PROCESSI NG	PURCHASING, RECEIVING, AND	
		(DEPARTMENT	(TELEPHONES)	(HARDWARE)	STORES	
			(GROSS			(PURCHASING)	
		1.00	<u>SALARI ES)</u> 4. 00	5.01	5. 02	5.03	
+	GENERAL SERVICE COST CENTERS			1			
	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	129, 668	20 120 049				1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS	540 291	39, 130, 048 15, 000	1			4.00 5.01
5.02	00550 DATA PROCESSI NG	678	1, 162, 508	1			5.02
	00590 PURCHASING, RECEIVING, AND STORES	729	226, 025			2, 060, 948	1
	00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE	1, 618	959, 924 541, 536	1	30 17	20, 806 15, 217	
	00592 OTHER ADMINISTRATIVE AND GENERAL	10, 613	4, 140, 867	1	50	34, 942	
	00700 OPERATION OF PLANT	11, 314	802, 128		-	2, 607	
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	555 257	31, 318 767, 797		1 27	70 32, 156	1
	01000 DI ETARY	2,462	169, 699			18, 307	
	01100 CAFETERI A	3, 899	383, 111			0	1
	01300 NURSI NG ADMI NI STRATI ON	1,683	1, 098, 634		14	37, 905	1
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	3, 181 1, 448	0 854, 099	5	3	66, 042 21, 145	
	01600 MEDICAL RECORDS & LIBRARY	2, 203	807, 955			9,057	1
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
	03000 ADULTS & PEDIATRICS	24, 273	5, 462, 434			255, 989	1
	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	7,433	1, 075, 094 0			117, 987 0	1
	04200 SUBPROVI DER	0	0			0	
	ANCI LLARY SERVICE COST CENTERS	0.700				500 (/0	
	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	9, 738	2, 971, 717			528, 662 0	
	05300 ANESTHESI OLOGY	471	2, 483, 890			98, 557	1
	05400 RADI OLOGY-DI AGNOSTI C	9, 293	2, 096, 882	1	34	48, 934	1
	05600 RADI OI SOTOPE	0	0	-	-	0	
	05601 ONCOLOGY 05700 CT SCAN	16, 618 400	1, 120, 687 316, 411			63, 453 23, 027	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	310, 063		4	11, 081	
	05900 CARDI AC CATHETERI ZATI ON	0	0	0	-	0	
	06000 LABORATORY 06001 BLOOD LABORATORY	2,005	1, 832, 889	22	40	205, 079 0	
	06500 RESPI RATORY THERAPY	836	802, 768		-	30, 180	1
	06501 SLEEP LAB	0	402, 031	4	6	18, 349	1
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	630 2, 823	1, 441, 915 478, 678		20 10	33, 611	66.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 823	50, 301		3	44, 457	1
	07200 IMPL. DEV. CHARGED TO PATIENT	0	41, 392	0	-	0	72.00
	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	73.00
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	89.00
	09000 CLINIC	4, 997	230, 291		4	6, 769	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 301	2, 377, 782	21	36	200, 512	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS			1			/2:00
	09500 AMBULANCE SERVICES	0	0			0	
	09700 DURABLE MEDICAL EQUIP-SOLD 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	-	0	97.00
	10100 HOME HEALTH AGENCY	0	771, 118			41, 216	
	SPECIAL PURPOSE COST CENTERS			-		, =	
	11300 I NTEREST EXPENSE	10(000			F (0)	1 00/ 117	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	126, 289	36, 226, 944	514	568	1, 986, 117	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	372	0	0	0	0	190.00
	19001 SHELBY COUNTY MEDICAL CENTER	0	0	0			190.01
	19002 SICK CHILD CARE 19003 PRIVATE DUTY	0	0	0	0		190. 02 190. 03
	19004 ST. VINCENT'S STRESS	0	0	0	0		190.03
190.05	19005 MARKETI NG	192	212, 576	0	2	0	190. 05
	19006 MH LIGHTBOUND	0	0	0	0		190.06
1911 11/	19007 I -74 CAMPUS 19008 SOUTHEAST OB	0	148, 069 0		5 0		190. 07 190. 08
					0	0	
190. 08 190. 09	19009 INTELLIPLEX DEVELOPMENT	0	12, 412	0	0		190. 09
190. 08 190. 09 190. 10		0	12, 412 0 0	0	-	0	190. 09 190. 10 190. 11

Health Financial Systems	MAJOR HOS	SPI TAL		In Lie	u of Form CMS-	2552-1
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150097	Period: From 01/01/2015	Worksheet B-1	
				To 12/31/2015	Date/Time Pre 4/28/2016 3:2	
	CAPI TAL					
	RELATED COSTS					
Cost Center Description	BLDG & FIXT		COMMUNI CATI ON		PURCHASING,	
	(SQUARE FEET)	BENEFITS			RECEIVING, AND	
		DEPARTMENT (GROSS	(TELEPHONES)	(HARDWARE)	STORES (PURCHASING)	
		SALARI ES)			(PURCHASTING)	
	1.00	4.00	5.01	5.02	5.03	
190. 12 19012 BARTLEY ORTHOPEDI CS	0	0		0 0		190. 1
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. 1
190. 16 19016 RENOVO	0	3, 894		0 0		190. 10
190. 17 19017 I MA	0	0		0 0		190. 1
190. 18 19018 MD SOLUTI ONS	0	0		0 0		190. 18
190. 19 19019 MHCD	264	0		0 0		190. 19
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0		192.00
192. 01 19201 HOSPI TALI ST	0	1, 870, 567		1 9		192. 0
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	2, 551	655, 586	1	5 10	74, 508	
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, 67	3, 697, 443	416, 108	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	19. 709150	0. 198445	39.00943	6, 224. 651515	0. 201901	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)		10, 643	5, 73	13, 950	14, 586	204. 00
205.00 Unit cost multiplier (Wkst. B, Part		0. 000272	10. 82830	23. 484848	0. 007077	205.00

	Financial Systems LLOCATION - STATISTICAL BASIS	MAJOR HO		CCN: 150097 P	In Lie eriod:	u of Form CMS-: Worksheet B-1	
					rom 01/01/2015 o 12/31/2015	Date/Time Pre 4/28/2016 3:2	
	Cost Center Description	ADMI TTI NG (GROSS CHARGES)	CASHI ERI NG/ACCF OUNTS RECEI VABLE (GROSS	Reconciliation	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM.	OPERATION OF PLANT (SQUARE FEET)	
			CHARGES)		COST)	·	
	GENERAL SERVICE COST CENTERS	5.04	5.05	5A. 06	5.06	7.00	
$\begin{array}{c} 1. \ 00\\ 4. \ 00\\ 5. \ 01\\ 5. \ 02\\ 5. \ 03\\ 5. \ 04\\ 5. \ 05\\ 5. \ 06\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATIONS 00550 DATA PROCESSING 00590 PURCHASING, RECEIVING, AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00592 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	258, 650, 519 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	258, 650, 519 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-8, 179, 411 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	69, 061, 402 2, 617, 094 239, 921 1, 534, 412 429, 770 566, 455 1, 559, 840 94, 898 6, 388, 204 1, 415, 362	103, 885 555 257 2, 462 3, 899 1, 683 3, 181 1, 448 2, 203	8.00 9.00 10.00 11.00 13.00 14.00 15.00
30.00	03000 ADULTS & PEDIATRICS	14, 945, 666	14, 945, 666	0	8, 788, 312	24, 273	30.00
31. 00 41. 00 42. 00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF 04200 SUBPROVI DER ANCI LLARY SERVI CE COST CENTERS	3, 781, 421 0 0	3, 781, 421 0 0	0 0 0	1, 945, 871 0	7, 433 0 0	41.00
50.00	05000 OPERATI NG 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	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	1, 214, 478 22, 171, 122	1, 214, 478 22, 171, 122	0	1, 454, 054 5, 003, 569	471 9, 293	•
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
56.01	05601 ONCOLOGY	11, 038, 165	11, 038, 165	0	2, 599, 469	16, 618	•
57.00	05700 CT SCAN	20, 376, 214	20, 376, 214	0	1, 066, 858	400	•
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	9, 906, 723	9, 906, 723	0	867, 051	0	58.00 59.00
60.00	06000 LABORATORY	35, 748, 815	35, 748, 815	0	5, 488, 495	2,005	•
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	3, 832, 347	3, 832, 347	0	1, 272, 398	836	•
65.01	06501 SLEEP LAB	4,069,354	4,069,354	0	755, 204	0	
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	6, 553, 297 5, 476, 487	6, 553, 297 5, 476, 487	0	2, 434, 886 859, 551	630 2, 823	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 442, 470		0		2, 023	•
	07200 I MPL. DEV. CHARGED TO PATIENT	7, 770, 168		0			72.00
	07300 DRUGS CHARGED TO PATIENTS	23, 505, 860		0		0	1
	OUTPATIENT SERVICE COST CENTERS	-	-		_	-	
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
	09000 CLINIC	220, 998	220, 998	0	214, 904	4, 997	•
91.00	09100 EMERGENCY	42, 392, 496		0	4, 626, 017	5, 301	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						1
	09500 AMBULANCE SERVI CES 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0	0	0	95.00 97.00
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
	10100 HOME HEALTH AGENCY	2, 182, 076	2, 182, 076	0	1, 575, 029		101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	050 (50 540		0 470 444	(0.001.007	100 50/	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	258, 650, 519	258, 650, 519	-8, 179, 411	62, 891, 897	100, 506	1118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7, 332	372	190.00
	19001 SHELBY COUNTY MEDICAL CENTER	0	0	0	0		190.01
190.02	19002 SICK CHILD CARE	0	0	0	0		190. 02
	19003 PRI VATE DUTY	0	0	0	0		190.03
	19004 ST. VINCENT'S STRESS	0	0	0	0 404 454		190. 04 190. 05
	19005 MARKETI NG 19006 MH LI GHTBOUND	0	0	0	424, 456 0		190.05
	19007 I -74 CAMPUS	0	0	0	715, 619		190.00
	19008 SOUTHEAST OB	0	0	0	0		190.08
	19009 INTELLIPLEX DEVELOPMENT	0	0	0	94, 116		190. 09
	19010 MS&M	0	0	0	0		190. 10
	19011 OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0		190.11
	19012 BARTLEY ORTHOPEDI CS 19013 SSA	0	0	0	0		190. 12 190. 13
. 70. 13	1	, U	, Ч	0	0	0	1170.10

Health Financial Systems	MAJOR HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150097	Period: From 01/01/2015	Worksheet B-1		
				To 12/31/2015	Date/Time Pre 4/28/2016 3:2		
Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC	Reconciliati		OPERATION OF		
	(GROSS	OUNTS		ADMI NI STRATI VE			
	CHARGES)	RECEI VABLE		AND GENERAL	(SQUARE		
		(GROSS		(ACCUM.	FEET)		
		CHARGES)		COST)			
	5.04	5.05	5A. 06	5.06	7.00		
190. 14 19014 SPORTSWORKS	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 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	0		0 1, 282, 170	264	190.19	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00	
192. 01 19201 HOSPI TALI ST	0	0	1	0 2, 504, 748	0	192.01	
194.0007950 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,	1, 474, 609	1, 769, 252		8, 179, 411	2, 927, 055	202.00	
Part I)							
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,	33, 240	654		212, 164	231, 617	204.00	
Part II)							
205.00 Unit cost multiplier (Wkst. B, Part	0. 000129	0. 000003		0.003072	2. 229552	205.00	
11)							

Total Total <th< th=""><th></th><th>Financial Systems LLOCATION - STATISTICAL BASIS</th><th>MAJOR HO</th><th></th><th></th><th><u>In Lie</u> eriod: com 01/01/2015</th><th>u of Form CMS-2 Worksheet B-1</th><th>2552-10</th></th<>		Financial Systems LLOCATION - STATISTICAL BASIS	MAJOR HO			<u>In Lie</u> eriod: com 01/01/2015	u of Form CMS-2 Worksheet B-1	2552-10
LINE SERVICE (USANCE (PAULAGE) (PAULAGE) (PAULAGE) (PAULAGE) (PAULAGE) (PAULAGE) (PAULAGE) 1:00 010000 0:00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 10.00 </th <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>								
OF-BRAIL SERVICE OWT PAYTRES 9.00 10.00 11.00 11.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 10.00		Cost Center Description	LINEN SERVICE (POUNDS OF	(SQUARE	(PATI ENT		ADMI NI STRATI ON	
1.00 00100 GAP REL C0315-BLDC & FHXIL 1.00 0.00 00100 GAP REL C0315-BLDC & FHXIL 1.00 5.01 01100 GAP REL C0315-BLDC & FHXIL 1.00 5.01 01100 GAP REL C0315-BLDC & FHXIL 1.00 5.01 01100 GAP REL C0315-BLDC & FHXIL 5.01 5.01 00500 GAP REL C0315-BLDC & FHXIL 5.01 5.01 00500 GAP REL FHXIL 5.01 5.00 00500 GAP REL C0315-BLDC & FHXIL 3.09 5.00 00500 GAP REL FHXIL 3.09 5.00 00500 GAP REL C0315-BLDC & FHXIL 3.09 5.00 00500 GAP REL FHXIL 0.01 5.00 00500 GAP REL C0315-BLDC & FHXIL 0.01 5.00 00500 GAP REL FHXIL 0.01 5.00 01000 GAP REL C0315-BLDC & FHXIL 0.01 10.00 00500 GAP REL FHXIL 0.01 10.00 01000 GAP REL FHXIL 0.01		r		9.00	10.00	11.00		
4 00 000400 INFL OVER ENFIRITS DEPARTMENT 4 .00 5 00 DEDESIDE MAA PRODESING. 100.00 1	1 00							1 00
5.06 00580 CASH ERINAZCOUNTS RECEIVABLE 5.06 5.00 00500 CASH ERINAZCOUNTS RECEIVABLE 5.06 7.00 00700 OPTRATI NO 'PLAN' 0 0.00 000000 000000 000	4.00 5.01 5.02 5.03	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG 00590 PURCHASI NG, RECEI VI NG, AND STORES						4.00 5.01 5.02 5.03
10. 00 01000 DETARY 0 2. 4c2 10. 422 0 10. 40 13. 00 01300 NURES MG ANDIM STRATION 0 1.60 0 30. 326 591,755 13. 00 14. 00 01300 NURES MG ANDIM STRATION 0 1.60 0 30. 336 591,755 13. 00 16. 00 01400 DECONDENCE COST CENTERS 0 2.003 0 75. 517 0 16. 00 10. 00 DIODON ANLIS & PIDIATRICS 150. 256 24. 273 9, 336 39. 00 59 39. 55 31. 00 16. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00	5.05 5.06 7.00 8.00	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00592 OTHER ADMI NI STRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE	389, 185	103 073				5.05 5.06 7.00 8.00
13. 00 01300 MINES INFANTION 0 1.643 0 30. 33. SP1, 795 13. 00 14. 00 01400 01500 FERRIL SERVICE COST & SUPPY 0 3. 181 0 0.3. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 16. 00 16. 0			0		10, 422			
14.00 01400 CENTRAL SERVICES & SUPPLY 0 3.181 0 14.00 0 0 14.00 0 0 0 14.00 0 14.00 0 14.00 0 0 0			0					
15: 00 01:500 PHAMECY 0 1,448 0 23,095 01 15: 00 IPART EAT ROUTLES ERVICE CODES & LIBRARY 0 2,203 0 355,517 0 10 0 <td></td> <td></td> <td>0</td> <td></td> <td>-</td> <td></td> <td></td> <td></td>			0		-			
IMPART FANT ROUTINE SERVICE COST CENTERS Impart FANT ROUTINE SERVICE COST CENTERS 00 03:00 01:00 01:00 01:00 01:00 01:00 01:00 01:00 01:00 01:00 01:00 01:00 01:00 01:00 01:00 0:0 0			-				-	
31.00 03100 NTERSIVE CARE UNIT 23.350 7.433 1.066 39.559 39.559 31.00 41.00 04200 SUBPROVIDER 0 <td< td=""><td>16.00</td><td></td><td>0</td><td>2, 203</td><td>0</td><td>35, 517</td><td>0</td><td>16.00</td></td<>	16.00		0	2, 203	0	35, 517	0	16.00
11.00 04100 SUBPROVIDER - IRF 0 0 0 0 0 0 0 10.0 <								
MACILLARY SERVICE COST CENTRES D <thd< th=""> D <thd< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></thd<></thd<>								
50. 00 65000 OPELATING ROOM 54. 242 9. 738 0 85. 523 85. 523 80. 00 52. 00 80. 00 52. 00 80. 00 52. 00 80. 00 52. 00 80. 00 52. 00 80. 00 52. 00 80. 00 52. 00	42.00		0	0	0	0	0	42.00
52.00 05200 DELLYERY ROOM & LABOR ROOM 0 <	50.00		54, 242	9, 738	0	85, 523	85, 523	50.00
54.00 054.00 RADIOLOGY-DIACMOSTIC 47,261 9,293 0 62,231 0 56.00 56.00 05600 NOLOCOY 0 16,618 0 36,654 36,654 56.00 57.00 05700 OTOCO T SCAN 0 400 0 11,885 57.00 57.00 58.00 OSBOO MACRETIC RESONANCE I MAGING (MRI) 0 0 0 0 58.00 59.00 50.00 71.00 70.00 70.00 <td< td=""><td></td><td></td><td>0</td><td>-</td><td></td><td>-</td><td></td><td></td></td<>			0	-		-		
56.00 056.00 NOSCOV 0			47, 261					
57.00 OS700 CT SCAN 0 400 0 11.665 0 57.00 57.00 0 <th< td=""><td></td><td>05600 RADI OI SOTOPE</td><td>0</td><td>0</td><td>Ű</td><td>0</td><td></td><td></td></th<>		05600 RADI OI SOTOPE	0	0	Ű	0		
99.00 05900 CARDIA C CATHETERIZATION 0 0 0 0 0 0 0 99.00 60.00 71.00 72.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 70.00 70.00 70.00 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
60 00 0000 LABORATORY 10, 864 2,005 0 82, 449 0 60, 00 13, 473 65, 00 66, 00 60, 00 60, 00 60, 00 60, 00 60, 00 60, 00 60, 00 71, 00 <			0	0	-		-	
65.00 0oSOO RESPIRATORY THERAPY 0 836 0 23.393 23.393 65.00 05.01 06501 15.1528 0 0 0 13.473 65.01 06.00 06900 PLSICAL THERAPY 15.338 63.0 0 42.621 18.442 18.442 69.00 071.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 35.39 0 71.00 0.00 072.00 ORDIGO RURAL HARGED TO PATIENTS 0 0 0 0 72.00 0.00 0000 RURAL HARGED TO PATIENTS 0 0 0 0 0 72.00 0.0000 RURAL HARGED TO PATIENTS 0 <td></td> <td></td> <td>0</td> <td>0 2, 005</td> <td></td> <td>-</td> <td>-</td> <td></td>			0	0 2, 005		-	-	
65 01 0c501 SLEEP LAB 0 0 0 0 0 13,473 65.01 66 00 06900 FLYSI CAL THERAPY 15,338 630 0 42,621 0 66.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 3,539 0 71.00 72.00 72000 INPL. EVC. CHARGED TO PATIENTS 0 0 0 3,539 0 72.00 00100 GUID SC CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 00100 FEDERALLY UGL OST CENTES 0 0 0 0 0 0 88.00 89.00 89.00 89.00 89.00 90.00			0	0	-	0	-	
69:00 06900 ELECTROCARDI OLOCY 3, 751 2, 823 0 18, 442 18, 442 69. 00 71:00 07100 MOTOM MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 3.539 0 71. 00 72:00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 00TATELIENT SERVICE COST CENTERS 0 <			0	0	0	23, 393		
11.00 O 0 3.539 0 71.00 72.00 07200 IMPL_DEV_CHARGED TO PATIENT 0 0 2.830 0 72.00 001720.00 IMPL_DEV_CHARGED TO PATIENTS 0					0			
73.0 0 07300 PRUESC CHARGED TO PATLENTS 0 0 0 0 0 73.00 0UTPATLENT SERVICE COST CENTERS 0 <t< td=""><td></td><td></td><td>3, 751</td><td></td><td>0</td><td></td><td></td><td></td></t<>			3, 751		0			
OUTPATIENT SERVICE COST CENTERS 0 <t< td=""><td></td><td></td><td>0</td><td>-</td><td></td><td></td><td></td><td></td></t<>			0	-				
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 1 3.44 4,997 0 8.681 8.681 90.00 91.00 90.00 91.00 0 0 0 0 0 90.00 91.00 91.00 0 0 0 0 0 0 91.00 91.00 0	73.00		0	0	0	0	0	/3.00
90.00 09000 CLINIC 1,344 4,997 0 8,681 8,681 90.00 91.00 09100 EMERGENCY 82,645 5,301 0 78,400 78,400 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92000 00 0 0 0 92.00 07HER REIMBURSABLE COST CENTERS 0 0 0 0 97.00 0 0 0 97.00 0 0 0 97.00 0 0 0 0 97.00 0			0	0	0	0	-	
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 95.00 09500 MBULANCE SERVICES 0 0 0 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 <td< td=""><td></td><td></td><td>1, 344</td><td>4, 997</td><td>0</td><td>8, 681</td><td></td><td></td></td<>			1, 344	4, 997	0	8, 681		
OTHER REIMBURSABLE COST CENTERS O <t< td=""><td></td><td></td><td>82, 645</td><td>5, 301</td><td>0</td><td>78, 400</td><td>78, 400</td><td></td></t<>			82, 645	5, 301	0	78, 400	78, 400	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 97.00 100.00 10000 I& SERVICES-NOT APPRVD PRGM 0	72.00	OTHER REIMBURSABLE COST CENTERS						72.00
100.00 18R SERVI CES-NOT APPRVD PRGM 0			0	0		-		
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 138.00 SUBTOTALS (SUM OF LINES 1-117) 389,051 99,694 10,422 805,476 540,221 118.00 NONREL MBURSABLE COST CENTERS Interest expenses Interest expenses 118.00 1190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 372 0 0 190.00 190.01 190.01 190.02 19002 SI CK CHI LD CARE 0 0 0 0 190.02 19002 SI CK CHI LD CARE 0 0 0 190.03 190.03 19003 PRI VATE DUTY 0 0 0 0 190.03 19005 MARKETI NG 0 190.05 0 0 0 190.05 190.05 190.05 190.05 190.06 190.06 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.06 190.06 190.06 190.06 190.06 190.06 190.06 190.06 190.06 190.06 190.06 190.06 190.06 190.06 190.06	100.00	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
113.00 INTEREST EXPENSE 389,051 99,694 10,422 805,476 540,221 113.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 389,051 99,694 10,422 805,476 540,221 118.00 NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 190.01 190.01 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.03 190.03 190.04 190.02 190.02 190.03 190.03 190.04 190.04 190.04 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.06 190.06 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.08 190.07 0 0 0 0 0 190.07	101.00		0	0	0	0	25, 913	101.00
190.01 19001 SHELBY COUNTY MEDI CAL CENTER 0 0 0 190.01 190.02 19002 SI CK CHI LD CARE 0 0 0 0 190.02 190.03 PRI VATE DUTY 0 0 0 0 0 190.03 190.04 19004 ST. VI NCENT'S STRESS 0 0 0 190.04 190.05 MARKETI NG 0 192 0 6.148 0 190.05 190.07 19006 MH LI GHTBOUND 0 0 0 0 0 190.06 190.07 19007 1-74 CAMPUS 0 0 0 0 0 190.07 190.09 19009 INTELI PLEX DEVELOPMENT 0 0 0 0 190.09 190.09 19009 INTELI PLEX DEVELOPMENT 0 0 0 0 190.09 190.10 1901 MS&M 0 0 0 0 0 190.10 190.10 19010 MS&M 0 0 0 0 0 190.10 </td <td></td> <td>11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)</td> <td>389, 051</td> <td>99, 694</td> <td>10, 422</td> <td>805, 476</td> <td></td> <td></td>		11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	389, 051	99, 694	10, 422	805, 476		
190.02 19002 SI CK CHI LD CARE 0 0 0 190.02 190.03 19003 PRI VATE DUTY 0 0 0 0 190.03 190.04 19004 ST. VI NCENT'S STRESS 0 0 0 0 190.04 190.05 19005 MARKETI NG 0 192 0 6,148 0 190.05 190.06 19006 MH LI GHTBOUND 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 0 190.08 190.10 19010 MS&M 0 0 0 0 190.04 190.11 190110 OTHER NON-REI MBURSEABLE CENTERS 0 0 0 0 190.10 190.12 19012 BARTLEY ORTHOPEDI CS 0 0 0 0 190.12 <t< td=""><td></td><td></td><td>0</td><td></td><td></td><td>-</td><td></td><td></td></t<>			0			-		
190.04 19004 ST. VINCENT'S STRESS 0 0 0 190.04 190.05 19005 MARKETING 0 192 0 6,148 0 190.05 190.06 19006 MH LI GHTBOUND 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-REI MBURSEABLE CENTERS 0 0 0 0 190.11 190.12 19012 BARTLEY ORTHOPEDI CS 0 0 0 0 190.12 190.13 19013 SSA 0 0 0 0 0 190.13			0	0	0	0		
190.05 19005 MARKETING 0 192 0 6, 148 0 190.05 190.06 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 1NTELLI PLEX DEVELOPMENT 0 0 0 694 190.09 190.10 19010 MS&M 0 0 0 0 190.10 190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 0 0 190.12 190.12 19012 BARTLEY ORTHOPEDICS 0 0 0 190.12 190.13 19013 SA 0 0 0 0 190.13			0	0	0	0		
190.07 1-74 CAMPUS 0 0 9,847 90.07 190.08 19008 SOUTHEAST OB 0 0 0 0 190.08 190.09 19009 INTELLI PLEX DEVELOPMENT 0 0 0 694 694 190.09 190.10 19010 MS&M 0 0 0 0 190.10 190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 0 190.10 190.12 19012 BARTLEY ORTHOPEDI CS 0 0 0 0 190.12 190.13 19013 SSA 0 0 0 0 190.13			0	0 192	0	0 6, 148		
190.08 19008 SOUTHEAST OB 0 0 0 190.08 190.09 19009 INTELLI PLEX DEVELOPMENT 0 0 0 694 694 190.09 190.10 19010 MS&M 0 0 0 0 190.10 190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 0 0 190.11 190.12 19012 BARTLEY ORTHOPEDI CS 0 0 0 0 190.12 190.13 19013 SSA 0 0 0 0 190.13			0	0	0	0		
190.10 19010 MS&M 0 0 0 190.10 190.11 19011 OTHER NON-REI MBURSEABLE CENTERS 0 0 0 0 190.11 190.12 19012 BARTLEY ORTHOPEDI CS 0 0 0 0 190.12 190.13 19013 SSA 0 0 0 0 0 190.13			0	0	0			
190.11 190.11 0THER_NON-RELIMBURSEABLE_CENTERS 0 0 0 190.11 190.12 19012 BARTLEY_ORTHOPEDI CS 0 0 0 0 190.12 190.13 19013 SSA 0 0 0 0 0 190.13			0	0	0	694		
190. 13 19013 SSA 0 0 0 0 190. 13			0	0	0	0		
			0	0	0	0		
			0	0	0	-		

ealth Financial Systems	MAJOR HO	SPI TAL		In Li€	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
		_		From 01/01/2015 To 12/31/2015		
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	NURSI NG	
	LINEN SERVICE		(PATI ENT	(MANHOURS)	ADMI NI STRATI ON	
	(POUNDS OF	FEET)	DAYS)			
	LAUNDRY)				(MANHOURS)	
	8.00	9.00	10.00	11.00	13.00	
90. 15 19015 SHELBY PEDS	0	0		0 0		190. 15
90. 16 19016 RENOVO	0	0 0		0 0		190. 16
90. 17 19017 I MA	0	0 0		0 0		190. 17
90. 18 19018 MD SOLUTI ONS	0	0 0		0 0		190. 18
90. 19 19019 MHCD	0	264		0 0		190. 19
92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
92. 01 19201 HOSPI TALI ST	0	0		0 18, 108		192.01
94.00079500THER 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
CO2.00 Cost to be allocated (per Wkst. B, Part I)	283, 975	1, 723, 384	591, 20	808, 593	1, 849, 335	202.00
203.00 Unit cost multiplier (Wkst. B, Part I) 0. 729666	16. 720033	56. 72663	0. 962298	3. 125012	203.00
Cost to be allocated (per Wkst. B, Part II)	12, 945	11, 466	56, 33	87, 817	46, 368	204. 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 033262	0. 111242	5. 40558	0. 104510	0. 078353	205.00

	Financial Systems LLOCATION - STATISTICAL BASIS	MAJOR HC		CCN: 150097	In Lieu of Form C Period: Worksheet	
				1	From 01/01/2015 To 12/31/2015 Date/Time	Prepared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (100% SUPPLI ES) 14.00	PHARMACY (100% DRUGS TO PATI ENTS) 15.00	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00	4/28/2016	3:20 pm
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT					1.00
$\begin{array}{c} 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG 00590 PURCHASI NG, RECEI VI NG, AND STORES 00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00592 OTHER ADMI NI STRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	100 0 0	100 0	261, 318, 88	5	$\begin{array}{c} 1.00\\ 4.00\\ 5.01\\ 5.02\\ 5.03\\ 5.04\\ 5.05\\ 5.06\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ \end{array}$
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	0	17, 873, 550		30.00
41.00	03100 INTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF 04200 SUBPROVI DER ANCI LLARY SERVI CE COST CENTERS	000000000000000000000000000000000000000	0 0 0		4 D D	31.00 41.00 42.00
	05000 OPERATI NG ROOM	0	0	34, 022, 96		50.00
53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0	1, 214, 478		52.00 53.00
	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	0	0	22, 171, 122 (2 0	54.00 56.00
	05601 ONCOLOGY 05700 CT SCAN	0	0	11, 038, 16 20, 376, 21		56.01 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	9, 906, 72		58.00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0	35, 748, 81	5	59.00 60.00
	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0	0	(3, 832, 34	2 7	60. 01 65. 00
65.01	06501 SLEEP LAB	0	0	4, 069, 354	4	65. 01
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0	0	6, 553, 29 ⁻ 5, 476, 48 ⁻		66.00 69.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	55	0	9, 442, 470		71.00
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	45 0	0 100	7, 770, 168 23, 505, 860		72.00 73.00
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	(า	88.00
89.00	08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0	(0	89.00
	09000 CLINIC 09100 EMERGENCY	0	0	220, 998 42, 392, 496		90.00 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					92.00
	09500 AMBULANCE SERVI CES	0	0	(0	95.00
	09700 DURABLE MEDICAL EQUIP-SOLD 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	(97.00 100.00
	10100 HOME HEALTH AGENCY	0	0	2, 182, 07	6	101.00
113.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	100	100	261, 318, 88	5	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	190. 00
	19001 SHELBY COUNTY MEDICAL CENTER 19002 SICK CHILD CARE	0	0	(190. 01 190. 02
190.03	19003 PRI VATE DUTY	0	0	(2	190. 03
	19004 ST. VINCENT'S STRESS 19005 MARKETING	0	0	(190. 04 190. 05
	19006 MH LIGHTBOUND 19007 I -74 CAMPUS	0	0	(190. 06 190. 07
190.08	19008 SOUTHEAST OB	0	0	(190. 08
	19009 INTELLIPLEX DEVELOPMENT 19010 MS&M	0	0	(190. 09 190. 10
190.11	19011 OTHER NON-REIMBURSEABLE CENTERS	0	0	(190. 11
400 1-	19012 BARTLEY ORTHOPEDICS	. 0		(1	190.12

Health Financial Systems	MAJOR HC	SPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150097	Peri od:	Worksheet B-1
				From 01/01/2015 To 12/31/2015	Date/Time Prepared: 4/28/2016 3:20 pm
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL		
		(100% DRUGS TO			
	SUPPLY	PATI ENTS)	LI BRARY		
	(100%		(GROSS		
	SUPPLIES)		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 I MA	0	0		0	190. 17
190. 18 19018 MD SOLUTI ONS	0	0		0	190. 18
190. 19 19019 MHCD	0	0		0	190. 19
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	192.00
192. 01 19201 HOSPI TALI ST	0	0		0	192.01
194.00 07950 OTHER NONREI MBURSABLE 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,	248, 951	7, 232, 038	1, 716, 07	77	202.00
Part I)		70,000,000,000		-	
203.00 Unit cost multiplier (Wkst. B, Part I)		72, 320. 380000			203.00
204.00 Cost to be allocated (per Wkst. B,	71, 024	54, 704	57, 49	92	204.00
Part II)	710 040000	F 47 0 40000	0,0000		205.00
205.00 Unit cost multiplier (Wkst. B, Part	710. 240000	547.040000	0.00022	20	205.00
11)		I			I

Health Financial Systems	MAJOR HC				u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre	pared:
		Ti +1	e XVIII	Hospi tal	4/28/2016 3: 2 PPS	0 pili
		1111		Costs	ггэ	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs		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		12, 456, 66	57 0	12, 456, 667	30.00
31. 00 03100 I NTENSI VE CARE UNI T	2, 773, 503		2, 773, 50	03 0	2, 773, 503	31.00
41. 00 04100 SUBPROVIDER - IRF	0			0 0	0	
42. 00 04200 SUBPROVI DER	0			0 0	0	42.00
ANCI LLARY SERVI CE COST CENTERS	1	1	1			
50. 00 05000 OPERATI NG ROOM	7, 257, 597		7, 257, 59		7, 257, 597	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	1, 733, 330		1, 733, 33		1, 886, 294	
54.00 05400 RADI OLOGY-DI AGNOSTI C	6, 253, 363		6, 253, 36	53 0	6, 253, 363	•
56. 00 05600 RADI OI SOTOPE	0			0 0	0	56.00
56. 01 05601 0NC0L0GY	3, 875, 727		3, 875, 72		3, 880, 556	
57.00 05700 CT SCAN	1, 356, 226		1, 356, 22		1, 356, 226	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 044, 747		1, 044, 74	47 0	1, 044, 747	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60. 00 06000 LABORATORY	6, 550, 583		6, 550, 58	33 0	6, 550, 583	
60. 01 06001 BLOOD LABORATORY	0		1 501 4	0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	1, 581, 411		.,		1, 581, 411	65.00
65. 01 06501 SLEEP LAB	913, 474		913, 47		913, 474	65.01
66. 00 06600 PHYSI CAL THERAPY	2, 846, 794		2, 846, 79		2, 848, 242	
69. 00 06900 ELECTROCARDI OLOGY	1, 202, 175		1, 202, 17		1, 202, 175	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	2,054,413		2,054,4		2,054,413	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 947, 541		1, 947, 54		1, 947, 541	
0UTPATIENT SERVICE COST CENTERS	7, 716, 102		7, 716, 10	02 0	7, 716, 102	/3.00
88.00 08800 RURAL HEALTH CLINIC	0	1	1	0 0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89.00
90. 00 09000 CLINIC	502, 616		502, 61	-	543, 792	
91. 00 09100 EMERGENCY	6, 071, 038		6, 071, 03		6, 445, 014	•
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 252, 863		1, 252, 86		1, 252, 863	•
OTHER REI MBURSABLE COST CENTERS	1,202,000	1	1,202,00		1,202,000	/2.00
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	100.00
101.00 10100 HOME HEALTH AGENCY	1, 856, 879		1, 856, 87	79	1, 856, 879	
SPECIAL PURPOSE COST CENTERS						1
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	71, 247, 049	0	71, 247, 04	19 574, 393	71, 821, 442	200.00
201.00 Less Observation Beds	1, 252, 863		1, 252, 86	53	1, 252, 863	
202.00 Total (see instructions)	69, 994, 186		69, 994, 18	36 574, 393	70, 568, 579	202 00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	MAJOR HOS		CCN: 150007	Period:	u of Form CMS-	2552-I
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider	CCN: 150097	From 01/01/2015	Worksheet C Part I	
				To 12/31/2015	Date/Time Pre	
					4/28/2016 3:2	0 pm
	-		e XVIII	Hospi tal	PPS	
		Charges	T I I I			
Cost Center Description	Inpati ent	Outpati ent	Total (col.		TEFRA	
			+ col. 7)	Ratio	Inpatient	
	6.00	7.00	8.00	9.00	Rati o 10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
30. 00 03000 ADULTS & PEDI ATRI CS	14, 905, 470		14, 905, 47	70		30.0
31. 00 03100 I NTENSI VE CARE UNI T	3, 521, 304		3, 521, 30			31.0
41. 00 04100 SUBPROVIDER - IRF	0, 321, 304		5, 521, 50	0		41.0
42. 00 04200 SUBPROVI DER	0			0		42.0
ANCI LLARY SERVICE COST CENTERS	0					72.0
50. 00 05000 OPERATING ROOM	8, 432, 287	25, 590, 674	34, 022, 96	0. 213315	0. 000000	1 50. O
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0, 102, 20,	20,070,071	01,022,70	0 0.000000	0. 000000	
53. 00 05300 ANESTHESI OLOGY	276, 677	937, 801	1, 214, 47		0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 419, 206	19, 751, 916			0. 000000	
56. 00 05600 RADI OI SOTOPE	0	0		0 0.000000	0. 000000	
56. 01 05601 0NC0L0GY	28, 116	11,010,049	11, 038, 16		0, 000000	
57. 00 05700 CT SCAN	3, 213, 876	17, 162, 338			0, 000000	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	956, 980	8, 949, 743	9, 906, 72		0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	.,,.	0 0.000000	0.000000	
60. 00 06000 LABORATORY	7, 393, 082	28, 355, 733	35, 748, 81		0.000000	
60. 01 06001 BLOOD LABORATORY	0	0		0 0.000000	0.000000	
65. 00 06500 RESPI RATORY THERAPY	3, 149, 062	683, 285	3, 832, 34		0. 000000	65.0
65. 01 06501 SLEEP LAB	9, 892	4, 059, 462	4, 069, 35		0. 000000	
66. 00 06600 PHYSI CAL THERAPY	1,039,640	5, 513, 657	6, 553, 29		0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	674, 874	4, 801, 613	5, 476, 48	0. 219516	0. 000000	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 886, 311	6, 556, 159	9, 442, 47	0. 217572	0. 000000	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	4, 035, 036	3, 735, 132	7, 770, 16	0. 250643	0. 000000	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 580, 426	15, 925, 434	23, 505, 86	0. 328263	0. 000000	73.0
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0		88.0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.0
90. 00 09000 CLINIC	202	220, 796	220, 99	2. 274301	0. 000000	90.0
91. 00 09100 EMERGENCY	6, 116, 393	36, 276, 103	42, 392, 49	0. 143210	0. 000000	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 968, 080	2, 968, 08	0. 422112	0.00000	92.0
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0	0		0 0. 000000	0.000000	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0. 000000	0. 000000	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0		100. 0
101.00 10100 HOME HEALTH AGENCY	0	2, 182, 076	2, 182, 07	76		101. 0
SPECIAL PURPOSE COST CENTERS	, · · · ·			-		
113.00 11300 INTEREST EXPENSE						113.0
200.00 Subtotal (see instructions)	66, 638, 834	194, 680, 051	261, 318, 88	35		200. 0
201.00 Less Observation Beds						201.0
202.00 Total (see instructions)	66, 638, 834	194, 680, 051	261, 318, 88	35		202.0

Health Financial Systems	MAJOR HOSPI	TAL	In Lie	u of Form CMS-2552-	-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	4/28/2016 3:20 pm	d:
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	•				
30. 00 03000 ADULTS & PEDI ATRI CS				30.	00
31.00 03100 INTENSIVE CARE UNIT				31.	00
41. 00 04100 SUBPROVI DER – I RF				41.	
42. 00 04200 SUBPROVI DER				42.	
ANCI LLARY SERVICE COST CENTERS				42.	00
50. 00 05000 OPERATING ROOM	0. 213315			50.	00
52. 00 05200 DELIVERY ROOM & LABOR ROOM				50.	
	0. 000000				
53. 00 05300 ANESTHESI OLOGY	1. 553173			53.	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 282050			54.	
56. 00 05600 RADI OI SOTOPE	0. 000000			56.	
56. 01 05601 ONCOLOGY	0. 351558			56.	
57.00 05700 CT SCAN	0. 066559			57.	00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 105458			58.	00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.	00
60. 00 06000 LABORATORY	0. 183239			60.	00
60.01 06001 BLOOD LABORATORY	0. 000000			60.	01
65. 00 06500 RESPI RATORY THERAPY	0. 412648			65.	00
65. 01 06501 SLEEP LAB	0. 224476			65.	
66. 00 06600 PHYSI CAL THERAPY	0. 434627			66.	
69. 00 06900 ELECTROCARDI OLOGY	0. 219516			69.	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 217572			71.	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 250643			71.	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 328263			72.	
OUTPATIENT SERVICE COST CENTERS	0. 328203			/3.	00
					~~
88.00 08800 RURAL HEALTH CLINIC				88.	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.440400			89.	
90. 00 09000 CLINIC	2. 460620			90.	
91.00 09100 EMERGENCY	0. 152032			91.	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 422112			92.	00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.	
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.	
202.00 Total (see instructions)				202.	
				1	-

Health Financial Systems	MAJOR HC	SPI TAL		In Lie	u of Form CMS-2	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prep	ared.
				10 12/31/2013	4/28/2016 3:20) pm
		Ti t	le XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	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		12, 456, 66	07 0	12, 456, 667	30.00
31.00 03100 INTENSIVE CARE UNIT	2, 773, 503		2, 773, 50	03 0	2, 773, 503	31.00
41. 00 04100 SUBPROVIDER - IRF	0			0 0	0	41.00
42. 00 04200 SUBPROVI DER	0			0 0	0	42.00
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	7, 257, 597		7, 257, 59	07 0	7, 257, 597	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	1, 733, 330		1, 733, 33	30 152, 964	1, 886, 294	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 253, 363		6, 253, 36	03 0	6, 253, 363	54.00
56. 00 05600 RADI OI SOTOPE	0			0 0	0	56.00
56. 01 05601 0NCOLOGY	3, 875, 727		3, 875, 72		3, 880, 556	56.01
57.00 05700 CT SCAN	1, 356, 226		1, 356, 22		1, 356, 226	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 044, 747		1, 044, 74	7 0	1, 044, 747	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60. 00 06000 LABORATORY	6, 550, 583		6, 550, 58	33 0	6, 550, 583	60.00
60. 01 06001 BLOOD LABORATORY	0			0 0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	1, 581, 411	0			1, 581, 411	65.00
65. 01 06501 SLEEP LAB	913, 474		913, 47		913, 474	65.01
66.00 06600 PHYSI CAL THERAPY	2, 846, 794		2, 846, 79		2, 848, 242	66.00
69.00 06900 ELECTROCARDI OLOGY	1, 202, 175		1, 202, 17		1, 202, 175	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	2,054,413		2, 054, 41		2,054,413	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 947, 541		1, 947, 54		1, 947, 541	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	7, 716, 102		7, 716, 10	02 0	7, 716, 102	73.00
88. 00 08800 RURAL HEALTH CLINIC	0	1		0 0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	88.00 89.00
90. 00 09000 CLINIC	502, 616		502, 61	-	543, 792	89.00 90.00
91. 00 09100 EMERGENCY	6, 071, 038		6, 071, 03		6, 445, 014	90.00 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 252, 863		1, 252, 86		1, 252, 863	91.00 92.00
OTHER REIMBURSABLE COST CENTERS	1, 232, 003		1, 232, 00		1, 232, 003	72.00
95. 00 09500 AMBULANCE SERVICES	0		1	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	°	100.00
101.00 10100 HOME HEALTH AGENCY	1, 856, 879		1, 856, 87	79	1, 856, 879	
SPECIAL PURPOSE COST CENTERS	1,000,077	1	1,000,07	·]	1,000,077	
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	71, 247, 049	l a	71, 247, 04	574, 393	71, 821, 442	
201.00 Less Observation Beds	1, 252, 863		1, 252, 86		1, 252, 863	
202.00 Total (see instructions)	69, 994, 186					
				1.1,0,0		

Health Financial Systems	MAJOR HOS	SPI TAL			u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre	pared:
					4/28/2016 3:2	
			le XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col.		TEFRA	
			+ col. 7)	Ratio	Inpati ent	
	(00	7.00	0.00	0.00	Ratio	
UNDATIONT DOUTING CODVICE COST CENTEDS	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	14 005 470		14 005 45	10		1 20 00
30. 00 03000 ADULTS & PEDIATRICS	14, 905, 470		14, 905, 47			30.00
31. 00 03100 INTENSIVE CARE UNIT	3, 521, 304		3, 521, 30			31.00
41. 00 04100 SUBPROVIDER - IRF	0			0		41.00
42. 00 04200 SUBPROVI DER	0			0		42.00
ANCI LLARY SERVI CE COST CENTERS	0 400 007	25 500 (74	24,022,07	1 0 010015	0,000000	50.00
50. 00 05000 OPERATING ROOM	8, 432, 287	25, 590, 674	34, 022, 96		0. 000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	027 001	1 014 4	0 0.00000	0. 000000	
53. 00 05300 ANESTHESI OLOGY	276, 677	937, 801	1, 214, 47		0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 419, 206	19, 751, 916	22, 171, 12		0. 000000	
56. 00 05600 RADI OI SOTOPE	0	0	11 000 1	0 0.00000	0.00000	
56. 01 05601 ONCOLOGY	28, 116	11,010,049			0. 000000	
57. 00 05700 CT SCAN	3, 213, 876	17, 162, 338			0. 000000	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	956, 980	8, 949, 743	9, 906, 72		0.00000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	7 202 002	0 255 722	25 740 01	0 0.00000	0. 000000	
	7, 393, 082	28, 355, 733	35, 748, 81		0. 000000	
60. 01 06001 BLOOD LABORATORY	2 140 0(2	(02, 205	2 022 2	0 0.00000	0. 000000	
65. 00 06500 RESPIRATORY THERAPY	3, 149, 062	683, 285	3, 832, 34		0. 000000	
65. 01 06501 SLEEP LAB	9, 892	4,059,462	4, 069, 35		0. 000000	
66. 00 06600 PHYSI CAL THERAPY	1,039,640	5, 513, 657	6, 553, 29		0.00000	
69. 00 06900 ELECTROCARDI OLOGY	674, 874	4,801,613	5, 476, 48		0. 000000	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	2, 886, 311	6, 556, 159			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	4,035,036	3, 735, 132	7, 770, 16		0.00000	
0UTPATIENT SERVICE COST CENTERS	7, 580, 426	15, 925, 434	23, 505, 86	0. 328263	0. 000000	73.00
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 0.00000	0. 000000	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.000000	0. 000000	
	Ŭ	0	220.00			
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	202	220, 796		-	0. 000000	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 116, 393 0	36, 276, 103 2, 968, 080	42, 392, 49		0.00000	
	0	2, 968, 080	2, 968, 08	0. 422112	0. 000000	92.00
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	0	0		0 0.000000	0,000000	95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0.000000	0.00000	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0.00000	0. 000000	100.00
101.0010000188 SERVICES-NOT APPRVD PRGM	0	0 2, 182, 076	2, 182, 07	16		100.00
SPECIAL PURPOSE COST CENTERS	0	2, 182, 076	2, 182, 07	U		101.00
113. 00 11300 I NTEREST EXPENSE	1 1					1113.00
200.00 Subtotal (see instructions)	66, 638, 834	194, 680, 051	261, 318, 88	5		200.00
201.00 Less Observation Beds	00, 030, 834	194, 000, 051	201, 318, 88			200.00
202.00 Total (see instructions)	66, 638, 834	194, 680, 051	261, 318, 88	25		201.00
	00, 030, 034	174,000,051	201, 310, 80		I	1202.00

Head th Financial Systems MAJOR HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 150097 Period: From 01/01/2015 Worksheet C Part I Date/Time Prepared: 2/21/2016 3: 20 pm Cost Center Description PPS Inpatient Ratio 11.00 Title XIX Hospital Cost INPATIENT ROUTINE SERVICE COST CENTERS 30.00 31.00 31.00 31.00 31.00 30.00 03000 INTENSIVE CARE UNIT 42.80 41.00 42.00 42.00 42.00 04200 SUBPROVIDER 0.000000 50.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 53.00 52.00 53.00 52.00 53.00 54.00 54.00 54.00 54.00 54.00 56.00
Cost Center Description PPS Inpatient Ratio PPS Inpatient Ratio Stress 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 41.00 04100 SUBPROVIDER - IRF 31.00 42.00 04200 SUBPROVIDER 42.00 ANCILLARY SERVICE COST CENTERS 42.00 50.00 055000 OPERATING ROOM 0.000000 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 53.00 05300 ANESTHESI OLGGY 0.000000 54.00 05400 RADI OLGY-DI AGNOSTI C 0.000000 56.01 05601 ONCOLOGY 0.000000 56.00 05600 RADI OLGY-DI AGNOSTI C 0.000000 56.01 05601 ONCOLOGY 0.000000 56.01 05600 MAGNETI C RESONANCE IMAGI NG (MRI) 0.000000 58.00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0.000000 58.00 05900 CARDI AC CATHERI ZATI ON 0.000000 58.00 59.00 05900 CARDI AC CATHERI ZATI ON 0.000000 59.00 59.00 05000 LABORATORY 0.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 30.00 03000 ADULTS & PEDI ATRI CS 31.00 31.00 03100 INTENSI VE CARE UNI T 31.00 41.00 SUBPROVI DER - 1 RF 41.00 42.00 O4200 SUBPROVI DER - 1 RF 42.00 ANCI LLARY SERVI CE COST CENTERS 50.00 50.00 OFERATI NG ROOM 0.000000 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 52.00 05300 ANESTHESI OLOGY 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 53.00 56.01 05600 RADI OLOGY-DI AGNOSTI C 0.000000 56.01 56.01 05600 RADI OLOGY MARCE I MAGI NG (MRI) 0.000000 56.01 57.00 05700 CT SCAN 0.000000 56.01 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 59.00 05900 CARDI AC CATHETERI ZATI O
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 30.00 03000 ADULTS & PEDI ATRI CS 30.00 31.00 03100 INTENSI VE CARE UNI T 31.00 41.00 O4100 SUBPROVI DER - I RF 41.00 42.00 O4200 SUBPROVI DER 42.00 ANCI LLARY SERVI CE COST CENTERS 42.00 50.00 05000 OPERATI NG ROOM 0.000000 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 D5400 RADI OLOGY-DI AGNOSTI C 0.000000 53.00 56.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 56.01 56.00 D5401 ON COLOGY 0.000000 56.01 56.01 57.00 05700 CT SCAN 0.000000 58.00 59.00 OS900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 59.00 OS900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 59.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 30.00 O3000 ADULTS & PEDI ATRI CS 31.00 31.00 O3100 INTENSI VE CARE UNI T 31.00 41.00 O4100 SUBPROVI DER - I RF 41.00 42.00 O4200 SUBPROVI DER 42.00 ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 0.000000 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 56.01 05601 ONCOLOGY 0.000000 56.01 57.00 05700 CT SCAN 0.000000 56.01 57.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 57.00 58.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 59.00 06000 LABORATORY 0.000000 59.00
30. 00 03000 ADULTS & PEDIATRICS 30. 00 31. 00 03100 INTENSIVE CARE UNIT 31. 00 41. 00 04100 SUBPROVIDER - 1 RF 41. 00 42. 00 04200 SUBPROVIDER 41. 00 ANCILLARY SERVICE COST CENTERS 42. 00 50. 00 05000 OPERATING ROOM 0. 000000 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0. 000000 53. 00 05300 ANESTHESI OLOGY 0. 000000 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 000000 56. 01 05601 ONCOLOGY 0. 000000 54. 00 56. 01 05601 ONCOLOGY 0. 000000 54. 00 57. 00 05700 CT SCAN 0. 000000 54. 00 58. 00 05600 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 000000 56. 01 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 58. 00 59. 00 06000 LABORATORY 0. 000000 59. 00 60. 01 06001 BLOOD LABORATORY 0. 0000000 60. 01 <
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 42.00 50.00 05000 OPERATING ROOM 0.000000 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 56.01 05601 ONCOLOGY 0.000000 54.00 56.01 05601 ONCOLOGY 0.000000 56.01 57.00 05700 CT SCAN 0.000000 57.00 58.00 05800 MAGNETI C RESONANCE I MAGING (MRI) 0.000000 57.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 60.00 06000 LABORATORY 0.000000 59.00
41.00 04100 SUBPROVI DER - I RF 41.00 42.00 04200 SUBPROVI DER 42.00 ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 0.000000 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 52.00 53.00 05300 ANSTHESI OLOGY 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 56.01 05600 RADI OLOGY 0.000000 54.00 56.01 05601 NCOLLOGY 0.000000 56.01 57.00 05700 CT SCAN 0.000000 56.01 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 58.00 59.00 05900 LABORATORY 0.000000 58.00 60.01 06001 BLOOD LABORATORY 0.000000 60.01
42.00 04200 SUBPROVI DER 42.00 ANCI LLARY SERVI CE COST CENTERS
42.00 04200 SUBPROVI DER 42.00 ANCI LLARY SERVI CE COST CENTERS
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 0.000000 50.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 56.01 05600 RADI OLOGY-DI AGNOSTI C 0.000000 56.00 56.01 05601 ONCOLOGY 0.000000 56.01 57.00 05700 CT SCAN 0.000000 56.01 58.00 058000 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 60.00 06000 LABORATORY 0.000000 60.01
50.00 05000 OPERATI NG ROOM 0.000000 50.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 56.00 05600 RADI OLOGY-DI AGNOSTI C 0.000000 56.00 56.01 05601 ONCOLOGY 0.000000 56.01 57.00 05700 CT SCAN 0.000000 56.01 58.00 058000 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 58.00 59.00 05900 CATRI AC CATHETERI ZATI ON 0.000000 59.00 60.00 06000 LABORATORY 0.000000 60.01
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 56.00 05600 RADI OLOGY-DI AGNOSTI C 0.000000 56.00 56.01 0S600 NOCOLOGY 0.000000 56.01 57.00 0S700 CT SCAN 0.000000 57.00 58.00 0S800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 57.00 59.00 CARDI AC CATHETERI ZATI ON 0.000000 59.00 59.00 60.00 LABORATORY 0.000000 60.01 60.01
53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 56.00 05600 RADI OL SOTOPE 0.000000 56.00 56.01 05601 ONCOLOGY 0.000000 56.01 57.00 05700 CT SCAN 0.000000 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 57.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 60.00 06000 LABORATORY 0.000000 60.01 60.01 BLOOD LABORATORY 0.000000 60.01
54.00 05400 RADI 0L0GY-DI AGNOSTI C 0.000000 54.00 56.00 05600 RADI 0I SOTOPE 0.000000 56.00 56.01 05601 0NCOLOGY 0.000000 56.01 57.00 05700 CT SCAN 0.000000 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 58.00 59.00 CARDI AC CATHETERI ZATI 0N 0.000000 58.00 60.00 LABORATORY 0.000000 60.01 60.01 BLOOD LABORATORY 0.000000 60.01
56.00 05600 RADI 0I SOTOPE 0.000000 56.00 56.01 05601 0NCOLOGY 0.000000 56.01 57.00 05700 CT SCAN 0.000000 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI 0N 0.000000 59.00 60.00 06000 LABORATORY 0.000000 60.01 60.01 06001 BLOOD LABORATORY 0.000000 60.01
56.01 05601 0NC0L0GY 0.000000 56.01 57.00 05700 CT SCAN 0.000000 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 60.00 06000 LABORATORY 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0.000000 60.01
57.00 05700 CT SCAN 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 60.00 06000 LABORATORY 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0.000000 60.01
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 60.00 06000 LABORATORY 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0.000000 60.01
59.00 05900 CARDI AC_CATHETERI ZATI ON 0.000000 59.00 60.00 06000 LABORATORY 0.000000 60.00 60.01 06001 BLOOD_LABORATORY 0.000000 60.01
60. 00 06000 LABORATORY 0. 000000 60. 00 60. 01 06001 BLOOD LABORATORY 0. 000000 60. 01
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 PHYSI CAL THERAPY 0. 000000 66. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 000000 71. 00
72. 00 07200 I MPL. 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 888.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00
90. 00 09000 CLINIC 0.000000 90. 00 90. 00
91.00 09100 EMERGENCY 0.000000 91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 92. 00
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES 0. 000000 95. 00
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM
101.00 10100 HOME HEALTH AGENCY 101.00
SPECIAL PURPOSE COST CENTERS
113. 00 11300 I NTEREST EXPENSE 113. 00
200.00 Subtotal (see instructions) 200.00
201.00 Less Observation Beds 201.00
202.00 Total (see instructions)

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI	TAL COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2015		nored.
				To 12/31/2015	Date/Time Pre 4/28/2016 3:2	pared:
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		•		·		
30.00 ADULTS & PEDIATRICS	664, 828	C	664, 82	8 10, 380	64.05	30.00
31.00 INTENSIVE CARE UNIT	186, 809		186, 80	9 1, 086	172.02	31.00
41.00 SUBPROVIDER - IRF	0	0)	0 0	0.00	41.00
42.00 SUBPROVI DER	0	0		0 0	0.00	42.00
200.00 Total (lines 30-199)	851, 637		851, 63	7 11, 466		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	4, 445		•			30.00
31.00 INTENSIVE CARE UNIT	560	96, 331				31.00
41.00 SUBPROVIDER – IRF	0	0				41.00
42. 00 SUBPROVI DER	0	0				42.00
200.00 Total (lines 30-199)	5,005	381, 033				200.00

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150097	Peri od:	Worksheet D	
				From 01/01/2015	Part II	
				To 12/31/2015	Date/Time Pre	pared:
					4/28/2016 3:2	<u>0 pm</u>
	0 1 1 1		e XVIII	Hospi tal	PPS	
Cost Center Description	Capital	Total Charges			Capital Costs	
	(from Wkst. B,	(from Wkst. C, Part I, col.		Program . Charges	(column 3 x column 4)	
	Part II, col.	8)	(COI. 1 ÷ COI 2)	. charges	Corumn 4)	
	26)	0)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	5.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	267, 260	34, 022, 961	0.00785	5 2, 762, 560	21, 700	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0		1			52.00
53. 00 05300 ANESTHESI OLOGY	20, 304	-				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	238, 136				14, 775	
56. 00 05600 RADI OI SOTOPE	200,100	22, 171, 122	0.0000		0	56.00
56. 01 05601 0NC0L0GY	386, 709	11, 038, 165				56.01
57. 00 05700 CT SCAN	20, 810					
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	7,487					
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.00000		0	59.00
60. 00 06000 LABORATORY	85, 760	35, 748, 815			9, 847	60.00
60. 01 06001 BLOOD LABORATORY	00,700	00,7,10,010	0.00000		0	60.01
65. 00 06500 RESPI RATORY THERAPY	29,006	3, 832, 347			-	
65. 01 06501 SLEEP LAB	5, 231	4,069,354				65.01
66. 00 06600 PHYSI CAL THERAPY	30,003					
69. 00 06900 ELECTROCARDI OLOGY	70, 992					
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	47,927					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	39, 896					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	63, 884					
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C	0.0000	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	0.0000	0 0	0	89.00
90. 00 09000 CLINIC	112,944	220, 998	0. 51106	03 0	0	90.00
91.00 09100 EMERGENCY	165, 999		0.00391	6 3, 229, 334	12, 646	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	66, 867	2, 968, 080	0. 02252			92.00
OTHER REIMBURSABLE COST CENTERS				ų		
95. 00 09500 AMBULANCE SERVICES						95.00
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0.0000	0 0	0	97.00
200.00 Total (lines 50-199)	1, 659, 215	240, 710, 035		23, 981, 716	114, 269	200. 00

Health Financial Systems	MAJOR HC	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 4/28/2016 3:2	
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
41.00 04100 SUBPROVIDER - IRF	0	0		0 0	0	41.00
42. 00 04200 SUBPROVI DER	0	0		0 0	0	42.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpati ent		
	Days	$5 \div col. 6$	Program Days			
	Jujo			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, 44	5 0		30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 086					31.00
41. 00 04100 SUBPROVI DER – I RF	1,000	0.00		0 0		41.00
42. 00 04200 SUBPROVI DER		0.00				42.00
200.00 Total (lines 30-199)	11 466		5, 00	5 0		200.00
200.00 10tal (11185 30-199)	11, 466	4	J 5, 00	0		IZUU. UU

Health Financial Systems	MAJOR HOS	SPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS		CCN: 150097	Period: From 01/01/2015 To 12/31/2015	4/28/2016 3:2	pared: O pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician I Anesthetist Cost	5		Medical Education Cost	4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1 1					-
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	00.00
56. 01 05601 ONCOLOGY	0	0		0 0	0	56.01
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
60. 00 06000 LABORATORY	0	0		0 0	0	
60.01 06001 BLOOD LABORATORY	0	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	
65.01 06501 SLEEP LAB	0	0		0 0	0	00101
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	
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	
89.00 08900 FEDERALLY QUALI FI ED HEALTH CENTER	0	0		0 0	0	89.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	
200.00 Total (lines 50-199)	0	0		0 0	0	200.00

Health Financial Systems	MAJOR HC	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2015 To 12/31/2015	Part IV	norod.
				To 12/31/2015	Date/Time Pre 4/28/2016 3:2	
		Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Total	Total Charges	Ratio of Cos		Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVICE COST CENTERS				0 0 00000	0.740.540	
50.00 05000 OPERATING ROOM	0				2, 762, 560	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	-			0	
53. 00 05300 ANESTHESI OLOGY	0	1,211,110			82, 231	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	22, 171, 122			1, 375, 561	54.00
56. 00 05600 RADI 0I SOTOPE	0		0.00000		0	56.00
56. 01 05601 0NCOLOGY 57. 00 05700 CT SCAN	0	11/000/100			24, 584	56.01
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	20/0/0/2/			1, 800, 622 497, 274	57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	9, 906, 723			497,274	58.00
60. 00 106000 LABORATORY		, s			4, 104, 661	60.00
60. 01 06001 BLOOD LABORATORY	0	35, 746, 615			4, 104, 001	60.00
65. 00 06500 RESPI RATORY THERAPY	0	3, 832, 347			1, 477, 739	
65. 01 06501 SLEEP LAB	0	4, 069, 354			4, 946	
66. 00 06600 PHYSI CAL THERAPY	0	6, 553, 297			677, 049	1
69. 00 06900 ELECTROCARDI OLOGY	0	5, 476, 487			659, 136	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9, 442, 470			1, 641, 457	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0				1, 796, 746	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0				3, 847, 816	
OUTPATIENT SERVICE COST CENTERS		20,000,000	0.00000	01000000	0/01//010	/ 0/ 00
88.00 08800 RURAL HEALTH CLINIC	0	C	0.00000	0 0.00000	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	89.00
90. 00 09000 CLINIC	0	220, 998			0	90.00
91. 00 09100 EMERGENCY	0				3, 229, 334	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0. 00000	0 0. 000000	0	97.00
200.00 Total (lines 50-199)	0	240, 710, 035			23, 981, 716	200. 00

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der	CCN: 150097	Period: From 01/01/2015	Worksheet D Part IV
THROUGH COSTS				To 12/31/2015	Date/Time Prepared:
					4/28/2016 3: 20 pm
			e XVIII	Hospi tal	PPS
Cost Center Description	Inpati ent	Outpati ent	Outpatient		
	Program	Program	Program	L	
	Pass-Through Costs (col. 8	Charges	Pass-Throug Costs (col.		
			· ·	9	
	x col. 10) 11.00	12.00	x col. 12) 13.00		
ANCI LLARY SERVI CE COST CENTERS	11.00	12.00	13.00		
50. 00 05000 OPERATING ROOM	0	7, 711, 073	1	0	50, 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	52.00
53. 00 05300 ANESTHESI OLOGY	0	215, 943		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	5, 293, 250		0	54.00
56. 00 05600 RADI 0L001-DI AGNOSTI C	0	0, 293, 200		0	56.00
56. 01 05601 0NC0L0GY	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 CARDI AC CATHETERI ZATI ON	0	2,207,380		0	59.00
60. 00 06000 LABORATORY	0	3, 751, 135		0	60,00
60. 01 06001 BLOOD LABORATORY	0	3,731,133		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 PHYSI CAL THERAPY	0	4, 647		0	66, 00
69. 00 06900 ELECTROCARDI OLOGY	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	<u> </u>	0,074,044	1	0	/ 3. 00
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	<u>ا</u>	017,204	1		,2:00
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
			•	1	

Health Financial Systems	MAJOR HC			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provi der	CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pre 4/28/2016 3:2	pared: 0 pm
		Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 O5000 OPERATI NG ROOM	0. 213315			0 0	1, 644, 888	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	1. 427222			0 0	308, 199	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 282050			0 0	1, 492, 961	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000			0 0	0	56.00
56. 01 05601 ONCOLOGY	0. 351121			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			0 0	232, 786	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			0 0	0	59.00
60. 00 06000 LABORATORY	0. 183239			0 0	687, 354	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			0 0	0	60. 01
65. 00 06500 RESPI RATORY 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 PHYSI CAL THERAPY	0. 434406	4, 647		0 0	2, 019	66.00
69. 00 06900 ELECTROCARDI OLOGY	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	т	I				
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	90.00
91.00 09100 EMERGENCY	0. 143210			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		95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			0 0	0	
200.00 Subtotal (see instructions)		51, 968, 059		0 19, 086	11, 817, 572	
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	I	51, 968, 059	l	0 19, 086	11, 817, 572	202.00

lealth Financial Systems	MAJOR HOS				u of Form CMS	-2552-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCI NE COST		CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pr 4/28/2016 3:	epared: 20 pm
			e XVIII	Hospi tal	PPS	_
	Cost					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
		Services Not				
	Subject To Ded. & Coins.	Subject To Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0,000	1100	1			
50. 00 05000 OPERATI NG ROOM	0	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
56. 00 05600 RADI OI SOTOPE	0	0				56.00
56. 01 05601 ONCOLOGY	0	0				56.0
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
50. 00 06000 LABORATORY	0	0				60.00
50. 01 06001 BLOOD LABORATORY	0	0				60.0
65. 00 06500 RESPIRATORY THERAPY	0	0				65.0
65. 01 06501 SLEEP LAB 66. 00 06600 PHYSI CAL THERAPY	0	0				65. 0 [°]
9. 00 06900 ELECTROCARDI OLOGY	0	0				69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0				72.0
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	6, 265	1			73.0
OUTPATIENT SERVICE COST CENTERS		0,200	1			
38.00 08800 RURAL HEALTH CLINIC	0	0				88. 00
39.00 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			1			
95. 00 09500 AMBULANCE SERVI CES	0					95.00
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0				97.00
200.00 Subtotal (see instructions)	0	6, 265				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
0nly Charges 202.00 Net Charges (line 200 +/- line 201)	0	6 745				202.00
$\frac{1}{2}$ $\frac{1}$	I U	6, 265	I			1202.00

OMPUT	Financial Systems MAJOR HOSPIT ATION OF INPATIENT OPERATING COST	Provider CCN: 150097	Peri od:	u of Form CMS-2 Worksheet D-1	2002
			From 01/01/2015 To 12/31/2015		
		Title XVIII	Hospi tal	4/28/2016 3: 20 PPS	o pr
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed days,			10, 380	1
00 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		ivate room days,	10, 380 0	2
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	d dave)		9, 336	4
00	Total swing-bed SNF type inpatient days (including private roor reporting period		er 31 of the cost	9, 330	5
00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	m days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8
00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	g swing-bed and	4, 445	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instructi		oom days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en	ly (including private r	room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period		e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year			0	13
	Medically necessary private room days applicable to the Program			0	14
. 00 . 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15 16
	SWING BED ADJUSTMENT		<u></u>		
	Medicare rate for swing-bed SNF services applicable to services reporting period	C		0.00	
. 00	Medicare rate for swing-bed SNF services applicable to services reporting period			0.00	
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	0		0.00	
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period		the cost	0.00	
. 00 . 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December		ing period (line	12, 456, 667 0	21
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3		0.1	0	23
. 00	Swing-bed cost applicable to NF type services through December			0	24
	7 x line 19)		0.1	0	
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20) Total swing-bed cost (see instructions)		, portou (rifie o	0	
. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		12, 456, 667	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.00000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 minu		u ons)	0.00	
. 00	Average per diem private room cost differential (line 34 x line	e 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an 27 minutine line 2()	nd private room cost di	fferential (line	0 12, 456, 667	36 37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			1 000 01	
. 00	Adjusted general inpatient routine service cost per diem (see i	-		1, 200. 06	
. 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program			5, 334, 267 0	39 40

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST		SPI TAL Provi der	CCN: 150097	Period: From 01/01/2015	worksheet D-1	1
					To 12/31/2015	4/28/2016 3:2	
	Cost Center Description	Total	Ti tl Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
	Cost center bescription	Inpatient Cost				(col. 3 x col. 4)	
	-	1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.
. 00	INTENSIVE CARE UNIT	2, 773, 503	1, 086	2, 553.	87 560	1, 430, 167	7 43.
. 00	CORONARY CARE UNI T	_,,	.,	_,		.,,	44.
. 00	BURN INTENSIVE CARE UNIT						45
	SURGI CAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46
. 00	Cost Center Description						47
						1.00	
. 00	Program inpatient ancillary service cost (Wks					5, 649, 444	
. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ons)		12, 413, 878	3 49
. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, su	n of Parts I and	381, 033	3 50
. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (fi	rom Wkst. D, s	sum of Parts II	114, 269	9 51
2. 00	Total Program excludable cost (sum of lines !	50 and 51)				495, 302	2 52
8.00	Total Program inpatient operating cost exclude	ding capital re	lated, non-phy	sician anest	netist, and	11, 918, 576	
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
. 00	Program di scharges					C	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					C	
. 00 . 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	rget amount (I	ine 56 minus	line 53)		
. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endina 1996. u	updated and co	ompounded by the		
	market basket	0 1	0				
. 00	Lesser of lines 53/54 or 55 from prior year of lines				the emount by	0.00	
. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					C) 61
	amount (line 56), otherwise enter zero (see i			00), 01 1,0 0	the target		
2.00	Relief payment (see instructions)					C	
. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see Enstru	ictions)			C) 63
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost report	ng period (See	C	64
	instructions)(title XVIII only)						
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the d	cost reporting	g period (See	C	65
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	55)(title XVI	ll only). For	C	66
	CAH (see instructions)						
7.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 d	of the cost re	eporting period	C	67
3. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	orting period	C	68
	(line 13 x line 20)				51		
9. 00	Total title V or XIX swing-bed NF inpatient			,		C) 69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili)	[70
. 00	Adjusted general inpatient routine service of	2		•			71
. 00	Program routine service cost (line 9 x line	,					72
. 00	Medically necessary private room cost applica Total Program general inpatient routine servi						73
. 00	Capital -related cost allocated to inpatient		,		Part II, column		75
	26, line 45)						
. 00	Per diem capital-related costs (line 75 ÷ lin	,					76
. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77
. 00	Aggregate charges to beneficiaries for excess		rovi der record	ls)			79
00	Total Program routine service costs for compa	arison to the c		· · · · · · · · · · · · · · · · · · ·	nus line 79)		80
. 00	Inpatient routine service cost per diem limit		`				81
. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s						82
. 00	Program inpatient ancillary services (see ins		,				84
. 00	Utilization review - physician compensation	(see instructio					85
. 00	Total Program inpatient operating costs (sum		rough 85)				86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					1, 044	1 87
	Adjusted general inpatient routine cost per o		line 2)			1, 200. 06	
3. 00	ling and a general infrations is a set to be a		11110 2)			.,	

Health Financial Systems	MAJOR HC	SPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 4/28/2016 3:2	
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(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. 05337	1 1, 252, 863	66, 867	90.00
91.00 Nursing School cost	0	12, 456, 667	0.00000	1, 252, 863	0	91.00
92.00 Allied health cost	0	12, 456, 667	0.00000	1, 252, 863	0	92.00
93.00 All other Medical Education	0	12, 456, 667	0.00000	1, 252, 863	0	93.00

	Financial Systems MAJOR HOSPIT ATLON OF INPATIENT OPERATING COST	AL Provider CCN: 150097	In Lie Period:	u of Form CMS-2 Worksheet D-1	2552-10
CONFUT	ATTON OF THEATTENT OPERATING COST		From 01/01/2015 To 12/31/2015	Date/Time Prep	parodi
				4/28/2016 3: 20	
	Cost Center Description	Title XIX	Hospi tal	Cost	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	Inpatient days (including private room days and swing-bed days,			10, 380	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		ivate room davs	10, 380 0	2.00 3.00
	do not complete this line.		, varo i com dajo,		
4.00 5.00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private roor		r 31 of the cost	9, 336	4.00 5.00
5.00	reporting period	a days) thi dagit becembe	1 51 01 the cost	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private roor	n days) after December	31 of the cost	0	6.00
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7.00
	reporting period	5, 6			
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	438	9.00
10 00	newborn days) Swing had SNE type inpatient days applicable to title XVIII. ap	v (including privato r	oom davc)	0	10 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi		oom days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
	through December 31 of the cost reporting period	5	3 /		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year			0	13.00
14.00	Medically necessary private room days applicable to the Program			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) SWING BED ADJUSTMENT			0	16.00
17.00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 o	f the cost	0.00	17.00
18.00	reporting period	after December 21 of	the east	0.00	10.00
16.00	Medicare rate for swing-bed SNF services applicable to services reporting period	saiter December 31 01	the cost	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19.00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20.00
01 00	reporting period			10 154 447	01 00
21.00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December		ing period (line	12, 456, 667 0	21.00 22.00
	5 x line 17)		0 1 1		
23.00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	31 of the cost reportin	g period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24.00
25.00	7 x line 19) Swing-bed cost applicable to NF type services after December 3 [°]	l of the cost reporting	poriod (line 9	0	25.00
25.00	x line 20)	i or the cost reporting	period (inne o	0	25.00
26.00	Total swing-bed cost (see instructions)			0	
27.00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		12, 456, 667	27.00
28.00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
	Semi-private room charges (excluding swing-bed charges)			0	30.00
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.00000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	in line 22) (cost int	tions)	0.00	
	Average per diem private room charge differential (line 32 minu		(10115 <i>)</i>	0.00	
35.00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 2 x line 25)	5 31/		0.00	35.00
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost ar	nd private room cost di	fferential (line	0 12, 456, 667	36.00 37.00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	TMENTS			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS		1	1 200 04	20 00
38.00	Adjusted general inpatient routine service cost per diem (see i			1, 200. 06	
39 00	Prodram deneral indatient routine service cost (ind y v inde	(K)			
	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program			525, 626 0	40.00

				CCN: 150097	Period: From 01/01/2015 To 12/31/2015		
						4/28/2016 3:2	
	Cost Costor Decesiation	T-+-1		I e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days			Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
. 00	NURSERY (title V & XIX only)	1.00	2.00	0.00	1.00	0.00	42.
	Intensive Care Type Inpatient Hospital Units						
. 00		2, 773, 503	1, 080	2, 553.	87 0	C	
. 00 . 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.
	SURGI CAL I NTENSI VE CARE UNI T						40.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description	•	•	•			
	Program inpatient ancillary service cost (Wks) Line 200)			1.00	1 40
. 00 . 00	Total Program inpatient anchiary service cost (WK			(sac		379, 904 905, 530	
00	PASS THROUGH COST ADJUSTMENTS			51137		703, 330	J 47
00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, su	m of Parts I and	0	50.
	111)						
00	Pass through costs applicable to Program inpa	atient ancillar	ry services (fi	rom Wkst. D,	sum of Parts II	C	51
00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				0	52
00	Total Program inpatient operating cost exclusion		ated, non-ph	ysician anest	hetist, and		
	medical education costs (line 49 minus line						
	TARGET AMOUNT AND LIMIT COMPUTATION					1	
00 00	Program di scharges					0.00	54
00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operati	ng cost and ta	arget amount (ine 56 minus	line 53)		
00	Bonus payment (see instructions)	5	5		,	C	58
00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996, i	updated and c	ompounded by the	0.00	59
00	market basket	act report un	datad by the	norkat bookat		0.00	0 60
. 00 . 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line:					0.00	
	which operating costs (line 53) are less that						
	amount (line 56), otherwise enter zero (see	nstructions)	•		Ū.		
	Relief payment (see instructions)					0	
00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)) 63
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost report	ing period (See	0	64
	instructions)(title XVIII only)	0			0.1		
00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the o	cost reportin	g period (See	C) 65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	no costs (lino	64 plus lipo	55) (+i +l o VVI	LL only) For	0	66
. 00	CAH (see instructions)		04 prus rine i	55)((1)(1) = XVI	ri oniy). Toi		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31	of the cost r	eporting period	C	67
	(line 12 x line 19)						
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost rep	orting period	C	68 0
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	coutine costs (line 67 + lin	- 68)			69
00	PART III - SKILLED NURSING FACILITY, OTHER NU						
00	Skilled nursing facility/other nursing facil)		70
00	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71
00	Program routine service cost (line 9 x line)		(lipo 14 v li	no 2E)			72
00	Medically necessary private room cost applica Total Program general inpatient routine serv						74
00	Capital -related cost allocated to inpatient				Part II, column		75
	26, line 45)						
00	Per diem capital-related costs (line 75 ÷ lin						76
00 00	Program capital -related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for exces		provi den inecon	ds)			78
00	Total Program routine service costs for comp	• •		· · ·	nus line 79)		80
00	Inpatient routine service cost per diem limi				<i>,</i>		81
00	Inpatient routine service cost limitation (I						82
00	Reasonable inpatient routine service costs (is)				83
00 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ns)				84
	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
. 00	Total observation bed days (see instructions)					1, 044	
. 00	Adjusted general inpatient routine cost per					1, 200. 06	

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 4/28/2016 3:2	
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(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. 05337	1 1, 252, 863	66, 867	90.00
91.00 Nursing School cost	0	12, 456, 667	0.00000	0 1, 252, 863	0	91.00
92.00 Allied health cost	0	12, 456, 667	0.00000	0 1, 252, 863	0	92.00
93.00 All other Medical Education	0	12, 456, 667	0.00000	1, 252, 863	0	93.00

leal th Financial Systems MAJOR HOS		001 450007		u of Form CMS-2	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150097	Period: From 01/01/2015	Worksheet D-3	5
			To 12/31/2015	Date/Time Pre	parec
				4/28/2016 3:2	
	Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			E E71 000		30.
30. 00 03000 AD0ETS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT			5, 571, 909 1, 475, 760		30.
41. 00 04100 SUBPROVI DER – I RF					41.
41. 00 04100 SUBPROVIDER - TRF 42. 00 04200 SUBPROVIDER			0		41.
ANCI LLARY SERVI CE COST CENTERS			0		42.
50. 00 05000 OPERATING ROOM		0. 2133	15 2, 762, 560	589, 295	50.
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 2133			1
53. 00 05300 ANESTHESI OLOGY		1. 55317		127, 719	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 28205		387,977	
56. 00 05600 RADI 0I SOTOPE		0. 2020		0	
56. 01 05601 ONCOLOGY		0. 35155			
57. 00 05700 CT SCAN		0. 06655			
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 10545			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 00000		0	
50. 00 06000 LABORATORY		0. 18323		752, 134	
50. 01 06001 BLOOD LABORATORY		0. 00000		0	
55. 00 06500 RESPIRATORY THERAPY		0. 41264		-	
55. 01 06501 SLEEP LAB		0. 22447			
56. 00 06600 PHYSI CAL THERAPY		0. 43462			
59. 00 06900 ELECTROCARDI OLOGY		0. 2195			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2175			
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 25064			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 32826			
OUTPATI ENT SERVICE COST CENTERS		0102020	5, 5, 5, 5, 7, 5, 10	172007070	1.0.
38. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.
39. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
20. 00 09000 CLINIC		2.46062	20 0	0	90.
91. 00 09100 EMERGENCY		0. 15203	32 3, 229, 334	490, 962	91.
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)		0. 4221		0	
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES					95.
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0. 00000	0 0	0	97.
200.00 Total (sum of lines 50-94 and 96-98)			23, 981, 716	5, 649, 444	200.
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.
202.00 Net Charges (line 200 minus line 201)	. ,	1	23, 981, 716		202.

Health Financial Systems MAJOR H		0.011 450.007		u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150097	Period: From 01/01/2015	Worksheet D-3	
			To 12/31/2015	Date/Time Pre 4/28/2016 3:2	
	Ti t	le XIX	Hospi tal	Cost	o pii
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			5	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 059, 599		30.0
31. 00 03100 I NTENSI VE CARE UNI T			147, 978		31.0
41. 00 04100 SUBPROVI DER – I RF			0		41.0
42. 00 04200 SUBPROVI DER			0		42.0
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 2133		77, 713	50.0
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000	0 00	0	52.0
53. 00 05300 ANESTHESI OLOGY		1. 4272	22 23, 602	33, 685	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2820	50 61, 396	17, 317	54.0
56. 00 05600 RADI 0I SOTOPE		0.0000	0 00	0	56.0
56. 01 05601 0NC0L0GY		0.3511	21 581	204	56.0
57. 00 05700 CT SCAN		0.0665	59 70, 578	4, 698	57.0
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 1054	58 21, 364	2, 253	58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000	0 00	0	59.0
60. 00 06000 LABORATORY		0. 1832	39 324, 116	59, 391	60.0
60. 01 06001 BLOOD LABORATORY		0.0000	0 00	0	60.0
65. 00 06500 RESPI RATORY THERAPY		0. 4126	48 113, 922	47, 010	65.0
65. 01 06501 SLEEP LAB		0. 2244		0	
66. 00 06600 PHYSI CAL THERAPY		0. 43440	06 11, 898	5, 169	66.0
69. 00 06900 ELECTROCARDI OLOGY		0. 2195	16 15, 729	3, 453	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2175	72 161, 225	35, 078	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 2506		0	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3282	63 286, 151	93, 933	73.0
OUTPATIENT SERVICE COST CENTERS		•			
88.00 08800 RURAL HEALTH CLINIC		0.0000	0 00	0	88. 0
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	0 00	0	89.0
90. 00 09000 CLINIC		2.2743	0 0	0	90.0
91. 00 09100 EMERGENCY		0. 1432	10 0	0	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4221	12 0	0	92.0
OTHER REIMBURSABLE COST CENTERS				-	1
95. 00 09500 AMBULANCE SERVI CES					95.0
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0.0000	0 00	0	
200.00 Total (sum of lines 50-94 and 96-98)			1, 454, 873		
201.00 Less PBP Clinic Laboratory Services-Program only char	rges (line 61)		0		201.0
202.00 Net Charges (line 200 minus line 201)	5	1	1, 454, 873		202.0

	Financial Systems MAJOR HOSPITA			In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Pre	parad
		Ti +1	e XVIII	Hospi tal	4/28/2016 3:2	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		0	1.00	2.00	_
1.00 1.01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring	prior		0 6, 217, 862		1.00 1.01
1.02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurring	•		2, 125, 992		1.02
	after October 1 (see instructions)			2, 123, 772		
1.03	DRG for federal specific operating payment for Model 4 BPCl for discharges occurring prior to October 1 (see instructions)			0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCl for discharges occurring on or after October 1 (see instructions)			0		1.04
2.00 2.01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			47, 378 0		2.00 2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instruction	s)		0		2. 02
3.00 4.00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporti	ng		0 58. 14		3.00 4.00
	period (see instructions) Indirect Medical Education Adjustment					1
5.00	FTE count for allopathic and osteopathic programs for the most r cost reporting period ending on or before 12/31/1996. (see instru			0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the	1		0.00		6.00
	criteria for an add-on to the cap for new programs in accordance CFR 413.79(e)	with 42				
7.00	MMA Section 422 reduction amount to the IME cap as specified unc CFR s412.105(f)(1)(iv)(B)(1)	ler 42		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified un CFR 412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1			0.00		7.01
0.00	then see instructions.			0.00		0.00
8.00	Adjustment (increase or decrease) to the FTE count for allopathi osteopathic programs for affiliated programs in accordance with	42 CFR		0.00		8.00
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 (August 1, 2002).	FR 50069				
8.01	The amount of increase if the hospital was awarded FTE cap slots section 5503 of the ACA. If the cost report straddles July 1, 20			0.00		8. 01
8. 02	instructions.			0.00		8. 02
	The amount of increase if the hospital was awarded FTE cap slots closed teaching hospital under section 5506 of ACA. (see instruc	tions)				
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines and 8,02) (see instructions)	(8, 8,01		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current from your records	year		0.00		10.00
11. 00 12. 00				0. 00 0. 00		11.00
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 or after September 30, 1997, otherwise enter zero.	ended on		0.00		14.00
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			0.00 0.00		15.00 16.00
17.00 18.00	Adjustment for residents displaced by program or hospital closur	e		0. 00 0. 00		17.00 18.00
19.00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			0. 000000		19.00
20. 00 21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0. 000000		20.00 21.00
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment – Managed Care (see instructions)			0		22. 00 22. 01
	Indirect Medical Education Adjustment for the Add-on for Section		he MMA			
23.00	Number of additional allopathic and osteopathic IME FTE resident slots under 42 Sec. 412.105 (f)(1)(iv)(C).	сар		0.00		23.00
24.00 25.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the low	er of		0.00 0.00		24.00 25.00
26.00	line 23 or line 24 (see instructions) 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 28. 01	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)			0		28. 00 28. 01
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29.00 29.01
30.00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pati	ent davs	·	4.40		30.00
	(see instructions)	uays				
31. 00 32. 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			20. 00 24. 40		31.00 32.00
33.00 34.00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			9. 34 194, 829		33.00 34.00
	· · · · · · · · · · · · · · · · · · ·					

.CUL/	Financial Systems MAJOR HOS ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150097	Period: From 01/01/2015	Worksheet E Part A	
			To 12/31/2015	4/28/2016 3:2	
		Title XVIII	Hospital Prior to October 1	PPS On/After October 1	
	Uncompensated Care Adjustment	0	1.00	2.00	
00	Total uncompensated care amount (see instructions)			6, 406, 145, 534	
01 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero,		0. 000054352 415, 665	0. 000051393 329, 233	
02	enter zero on this line) (see instructions)		415,005	329, 233	30.
03	Pro rata share of the hospital uncompensated care payment		310, 895	82, 758	35.
00	amount (see instructions) Total uncompensated care (sum of columns 1 and 2 on line		393, 653		36.
	35.03)				
	Additional payment for high percentage of ESRD beneficiary d Total Medicare discharges on Worksheet S-3, Part I	lischarges (lines 40 through	gh 46) 0		40.
	excluding discharges for MS-DRGs 652, 682, 683, 684 and				
00	685 (see instructions)		0		41
00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.
01	Total ESRD Medicare covered and paid discharges excluding		0		41.
00	MS-DRGs 652, 682, 683, 684 an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.
	qualify for adjustment)		0.00		
00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.
00	682, 683, 684 an 685. (see instructions) Ratio of average length of stay to one week (line 43		0. 000000		44.
	divided by line 41 divided by 7 days)				
00	Average weekly cost for dialysis treatments (see instructions)		0.00		45
00	Total additional payment (line 45 times line 44 times line		0		46.
00	41.01) Subtotal (see instructions)		8, 979, 714		47.
00	Hospital specific payments (to be completed by SCH and		0, 979, 714		48
~~	MDH, small rural hospitals only. (see instructions)		0 070 744		
00	Total payment for inpatient operating costs (see instructions)		8, 979, 714		49
00	Payment for inpatient program capital (from Wkst. L, Pt. I		668, 316		50
00	and Pt. II, as applicable) Exception payment for inpatient program capital (Wkst. L,		0		51.
00	Pt. III, see instructions)		0		51.
00	Direct graduate medical education payment (from Wkst. E-4,		0		52.
00	line 49 see instructions). Nursing and Allied Health Managed Care payment		0		53
00	Special add-on payments for new technologies		0		54
00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.
00	Cost of physicians' services in a teaching hospital (see		0		56
00	intructions)		0		57
00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.
00	Ancillary service other pass through costs from Wkst. D,		0		58
00	Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58)		9, 648, 030		59
00	Primary payer payments		2, 926		60
00	Total amount payable for program beneficiaries (line 59		9, 645, 104		61
00	minus line 60) Deductibles billed to program beneficiaries		1, 063, 952		62
00	Coinsurance billed to program beneficiaries		18, 900		63
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		44, 171 28, 711		64 65
	Allowable bad debts for dual eligible beneficiaries (see		44, 171		66
00	instructions)		8, 590, 963		67
00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices		0, 590, 963		68
	for applicable to MS-DRGs (see instructions)		_		
00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70
1	RURAL DEMONSTRATION PROJECT		0		70
89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70
90	HSP bonus payment HVBP adjustment amount (see		0		70
91	instructions) HSP bonus payment HRR adjustment amount (see instructions)		0		70
	Bundled Model 1 discount amount (see instructions)		0		70
93	HVBP payment adjustment amount (see instructions)		31, 696		70.
94	HRR adjustment amount (see instructions) Recovery of accelerated depreciation		-7, 574 0		70 70

	Financial Systems MAJOR HOS			u of Form CMS-	2002-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Pre	parod:
			10 12/31/2015	4/28/2016 3:2	
		Title XVIII	Hospi tal	PPS	
			Prior to	0n/After	
	_		October 1	October 1	
70.0/		0	1.00	2.00	70.0/
70. 96	Low volume adjustment for federal fiscal year (yyyy)	20	15 143, 037		70.96
	(Enter in column 0 the corresponding federal year for the period prior to 10/1)				
70 07	Low volume adjustment for federal fiscal year (yyyy)	20	16 60, 790		70.97
10. 71	(Enter in column 0 the corresponding federal year for the	20	10 00, 770		/0. //
	period ending on or after 10/1)				
70. 98	Low Volume Payment-3		0		70.98
	HAC adjustment amount (see instructions)		0		70.99
	Amount due provider (line 67 minus lines 68 plus/minus		8, 818, 912		71.00
	lines 69 & 70)				
71.01	Sequestration adjustment (see instructions)		176, 378		71.01
	Interim payments		8, 580, 528		72.00
	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01,		62, 006		74.00
75 00	72, and 73)		1 700 (71		
75.00	Protested amounts (nonallowable cost report items) in		1, 722, 671		75.00
	accordance with CMS Pub. 15-2, chapter 1, §115.2				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see		0		90.00
70.00	instructions)		0		70.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
	Operating outlier reconciliation adjustment amount (see		0		92.00
	instructions)				
93.00	Capital outlier reconciliation adjustment amount (see		0		93.00
	instructions)				
94.00	The rate used to calculate the time value of money (see		0.00		94.00
	instructions)				
95.00	Time value of money for operating expenses (see		0		95.00
04 00	instructions)		0		96.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	$\Omega n/After 10/1$	
			1.00	2.00	
	HSP Bonus Payment Amount		1.00	2.00	
	HSP bonus amount (see instructions)		0	0	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.000000000	0.000000000	101.00
	HVBP adjustment amount for HSP bonus payment (see instruction	ons)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment				
	HRR adjustment factor (see instructions)		0.0000		103.00
10/ 00	HRR adjustment amount for HSP bonus payment (see instruction	15)	0		104.00

	Financial Systems LUME CALCULATION EXHIBIT 4		MAJOR HO			eriod: rom 01/01/2015	u of Form CMS-2 Worksheet E Part A Exhibi Date/Time Pre 4/28/2016 3:20	t 4 pared:
		W/S E, Part A line	Amounts (from E, Part A)	Titl Pre/Post Entitlement	e XVIII Period Prior to 10/01	Hospital Period On/After 10/01	PPS Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier	1.00	0	0		0	0	1.00
1. 01	payments DRG amounts other than outlier payments for discharges	1.01	6, 217, 862	0	6, 217, 862	0	6, 217, 862	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	2, 125, 992	0	0	2, 125, 992	2, 125, 992	1. 02
1. 03	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1. 04	DRG for Federal specific operating payment for Model 4 BPCl occurring on or after	1.04	0	0	0	0	0	1. 04
2.00	October 1 Outlier payments for discharges (see instructions)	2.00	47, 378	0	44, 760	2, 618	47, 378	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2. 01
3.00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
5.00	Indirect Medical Education Adju Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000	0.000000	0. 000000		5.00
6.00	IME payment adjustment (see	22.00	0	0	0	0	0	6.00
6. 01	instructions) IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6. 0 [.]
	Indirect Medical Education Adju	ustment for the	e Add-on for Se	ction 422 of t	he MMA			
7.00	IME payment adjustment factor	27.00	0. 000000	0.00000		0. 000000		7.0
8.00	(see instructions) IME adjustment (see	28.00	о	0	0	0	0	8.0
3. 01	instructions) IME payment adjustment add on for managed care (see	28.01	0	0	0	0	0	8. 0
9.00	instructions) Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.0
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.0
	Disproportionate Share Adjustme		0.000.4	0.0001	0. 0934	0. 0934		10 0
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0934	0. 0934	0. 0934	0. 0934		10. C
11.00	Disproportionate share adjustment (see instructions)	34.00	194, 829	0		49, 642	194, 829	
11.01	Uncompensated care payments Additional payment for high per	36.00 Centage of ESE	393, 653 D benefi ci arv	0 di scharges	310, 895	82, 758	393, 653	11.0
12.00	Total ESRD additional payment	46.00	0	0 O	0	0	0	12.0
13. 00 14. 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47.00 48.00	8, 979, 714 0	0 0	6, 718, 704 0	2, 261, 010 0	8, 979, 714 0	
15.00	(see instructions) Total payment for inpatient operating costs (see	49.00	8, 979, 714	0	6, 718, 704	2, 261, 010	8, 979, 714	15. 0
16. 00	instructions) Payment for inpatient program	50.00	668, 316	0	497, 728	170, 588	668, 316	16. 0
17.00	capital Special add-on payments for	54.00	о	0	0	0	0	17.0
17. 01 17. 02	new technologies Net organ aquisition cost Credits received from manufacturers for replaced	55.00 68.00	0 0	0 0	0	0 0	0 0	
18. 00	manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18. 0

Health Financial Systems		MAJOR HO	SPI TAL		In Lie	u of Form CMS-:	2552-10
LOW VOLUME CALCULATION EXHIBIT 4				-	Period: From 01/01/2015 Fo 12/31/2015	Date/Time Pre 4/28/2016 3:2	pared:
			Ti tl	e XVIII	Hospi tal	PPS	
	W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
	line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
	0	1.00	2.00	3.00	4.00	5.00	
19.00 SUBTOTAL			0	7, 216, 432	2 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	3 170, 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	5.00	0. 0000	0.0000	0.000	0.0000		22.00
percentage (see instructions)							
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	0.000	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	3 170, 588	668, 316	26.00
	W/S E, Part A	(Amounts to E,					
	line	Part A)					
	0	1.00	2.00	3.00	4.00	5.00	
27.00 Low volume adjustment factor				0. 01982	0. 025000		27.00
28.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			143, 03	7	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 5Provider CCN: 150097Period: From 01/01/2015 To 12/31/2015Worksheet E Part A Exhibition Date / Time Priod 4/28/2016 3:Title XVIIIHospitalPeriod : Part A Exhibition Date / Time Priod 4/28/2016 3:Title XVIIIHospitalPeriod to 10/01Total (cols. 2 and 3)Interview of the second seco	20 pm 1. 00 1. 01
Wkst. E, Pt. A, lineAmt. from Wkst. E, Pt. A)Period to 10/01Period on after 10/01Total (cols. 2 and 3)1.00DRG amounts other than outlier payments 	1.00 1.01
A, line Wkst. E, Pt. A) 10/01 after 10/01 and 3) 0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier payments discharges occurring prior to October 1 1.01 6, 217, 862 6, 217, 862 6, 217, 862 1.02 DRG amounts other than outlier payments for 1.02 2, 125, 992 2, 125, 992 2, 125, 992	1.00 1.01
0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier payments 1.00 6,217,862	1. 01
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 1.02 DRG amounts other than outlier payments for 1.02 2,125,992 <td< td=""><td>1. 01</td></td<>	1. 01
discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 2,125,992 2,125,992 2,125,992	
	1.02
1.03 DRG for Federal specific operating payment 1.03 0 0 for Model 4 BPCI occurring prior to October 1	1.03
1.04 DRG for Federal specific operating payment 1.04 0 0 0 for Model 4 BPCI occurring on or after 0 0 0 0 October 1 0 0 0 0 0	1.04
2.00 Outlier payments for discharges (see 2.00 47,378 44,760 2,618 47,378 instructions) 1	2.00
2.01 Outlier payments for discharges for Model 4 2.02 0 0 0 0	2. 01
3.00 Operating outlier reconciliation 2.01 0 0 0	
4.00 Managed care simulated payments 3.00 0 0 0	4.00
Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, Line 21 21.00 0.000000 0.000000 0.000000	5.00
(see instructions)22.00006.00IME payment adjustment (see instructions)22.0000	6.00
6.00IME payment adjustment (see instructions)22.000006.01IME payment adjustment for managed care (see instructions)22.01000	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA	
7.00 I ME payment adjustment factor (see 27.00 0.000000 0.000000 0.000000 i nstructi ons) 0.000000 0	7.00
8.00IME adjustment (see instructions)28.000008.01IME payment adjustment add on for managed care (see instructions)28.01000	
9.00 Total IME payment (sum of lines 6 and 8) 29.00 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	9.01
Di sproporti onate Share Adjustment	10.00
10. 00 Allowable disproportionate share percentage (see instructions) 33. 00 0. 0934 0. 0934	10.00
11.00Disproportionate share adjustment (see34.00194,829145,18749,642194,824instructions)194,829145,187194,829145,187145,187194,824	
11.01 Uncompensated care payments 36.00 393, 653 310, 895 82, 758 393, 653 Additional payment for high percentage of ESRD beneficiary discharges	11.01
	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 48.00 0 0 0	
instructions) 15.00 Total payment for inpatient operating costs 49.00 8,979,714 6,718,704 2,261,010 8,979,714 (see instructions)	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	1
17.01 Net organ aquisition cost 55.00 0	
17.02 Credits received from manufacturers for 68.00 0 0 0	17.02
replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0	18.00
amount (see instructions) 19.00 SUBTOTAL 7, 216, 534 2, 431, 496 9, 648, 030	19.00

	Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5		CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 4/28/2016 3:2	pared:
				e XVIII	Hospi tal	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, 3	49 170, 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	4	81 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	0.00	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	0.00	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00	· · · · · · · · · · · · · · · · · · ·	12.00	668, 316	497, 8	30 170, 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, 0	37	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, 9	20, 793	31, 696	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	1
31.00	HRR adjustment (see instructions)	70, 94	-7, 574	-3, 1	-4, 465	-7, 574	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	1
						(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

	Financial Systems MAJOR HOSPIT	AL		u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150097	Period: From 01/01/2015		
			To 12/31/2015	Date/Time Pre 4/28/2016 3:2	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructi	ons)		6, 265 11, 817, 572	•
3.00	PPS payments	0113)		9, 715, 825	•
4.00	Outlier payment (see instructions)			11, 522	•
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0.000	•
6.00 7.00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0 0.00	
8.00	Transitional corridor payment (see instructions)			0.00	1
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IN	/, col. 13, line 200		0	1
	Organ acquisitions			0	
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			6, 265	11.00
	Reasonable charges				1
	Ancillary service charges			19, 086	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lir	ne 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			19, 086	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for pa	wment for services on	a charge basis	0	15.00
	Amounts that would have been realized from patients liable for			0	
	had such payment been made in accordance with 42 CFR §413.13(e)		-		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	/ifline 18 exceeds li	ne 11) (see	19, 086 12, 821	•
17.00	instructions)			12, 021	
20.00	Excess of reasonable cost over customary charges (complete only	/ifline 11 exceeds li	ne 18) (see	0	20.00
21 00	instructions)	instructions)		()(F	21.00
	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)	riisti ucti olis)		0, 205	
	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	•
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			9, 727, 347	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			0	25.00
	Deductibles and Coinsurance relating to amount on line 24 (for	CAH. see instructions)		2, 094, 441	•
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			7, 639, 171	•
~~ ~~	instructions)	50)			
	Direct graduate medical education payments (from Wkst. E-4, lir ESRD direct medical education costs (from Wkst. E-4, line 36)	ie 50)		0	
	Subtotal (sum of lines 27 through 29)			7, 639, 171	•
	Primary payer payments			5, 761	•
	Subtotal (line 30 minus line 31)			7, 633, 410	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. I-5, line 11)	.S)		0	33.00
	Allowable bad debts (see instructions)			274, 974	
	Adjusted reimbursable bad debts (see instructions)			178, 733	•
	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		274, 974	
	Subtotal (see instructions)			7, 812, 143 -189	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			- 189 0	
	Pioneer ACO demonstration payment adjustment (see instructions)			0	•
39. 98	Partial or full credits received from manufacturers for replace	ed devices (see instruc	tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
	Subtotal (see instructions) Sequestration adjustment (see instructions)			7, 812, 332 156, 247	
	Interim payments			7, 617, 315	1
	Tentative settlement (for contractors use only)			0	42.00
	Balance due provider/program (see instructions)			38, 770	1
44.00	Protested amounts (nonallowable cost report items) in accordance §115.2	e with CMS PUD. 15-2,	chapter I,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				1
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	•
92. UU	The rate used to calculate the Time Value of Money			0.00	•
93,00	Time Value of Money (see instructions)			0	93.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part I Date/Time Prep 4/28/2016 3:20	
		Ti †l (e XVIII	Hospi tal	472872018 3.20 PPS) pili
		Inpatien			t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider 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		8, 550, 49	8 0	7, 479, 046 0	1.00 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) Program to Provider					3.00
3.01	ADJUSTMENTS TO PROVIDER	12/31/2015	30, 03	0 12/31/2015	138, 269	3. 01
3.02				0	0	3. 02
3.03 3.04				0	0	3. 03 3. 04
3.04				0	0	3.04
5.05	Provider to Program	<u> </u>		0		5.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3. 51
3.52				0	0	3.52
3.53 3.54				0	0	3.53 3.54
3. 99 3. 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines		30, 03	-	138, 269	3.99
4.00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		8, 580, 52	8	7, 617, 315	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
- 00	TO BE COMPLETED BY CONTRACTOR	1				F 00
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
5.01	Program to Provider TENTATIVE TO PROVIDER			0	0	5. 01
5.01				0	0	5. 01
5.03				0	0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51 5.52				0	0	5.51 5.52
5.52 5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.92 5.99
5. 77	5. 50-5. 98)					5. 7.
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		62,00	6	38, 770	6. 01
6.02	SETTLEMENT TO PROGRAM		,	0	0	6. 02
7.00	Total Medicare program liability (see instructions)		8, 642, 53		7, 656, 085	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				Number		

Heal th	Financial Systems MAJOR HO	SPI TAL	In Lie	u of Form CMS-2	2552-10
CALCU	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 150097	Period: From 01/01/2015	Worksheet E-1 Part II	
			To 12/31/2015		
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI				
1.00	Total hospital discharges as defined in AARA §4102 from Wks		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	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3			5, 409, 857	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	<pre>certified HIT technology</pre>	Wkst. S-2, Pt. I	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	on (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	lline 31) (see instruction	s)	0	32.00

	Financial Systems MAJOR HOSPI ATION OF RELIMBURSEMENT SETTLEMENT MAJOR HOSPI	Provider CCN: 150097	Peri od:	u of Form CMS-2 Worksheet E-3	
LCUL	ATTON OF REIMBORSEMENT SETTLEMENT	PLOVIDEL CCN. 150097	From 01/01/2015	Part VII	
			To 12/31/2015	Date/Time Pre 4/28/2016 3:20	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpatient	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR X	1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES		TX SERVICES		1
00	Inpatient hospital/SNF/NF services		905, 530		1.0
00	Medical and other services			0	2.0
00	Organ acquisition (certified transplant centers only)		0	_	3.0
00	Subtotal (sum of lines 1, 2 and 3)		905, 530	0	
00 00	Inpatient primary payer payments Outpatient primary payer payments		0	0	5. 6.
00	Subtotal (line 4 less sum of lines 5 and 6)		905, 530	0	
00	COMPUTATION OF LESSER OF COST OR CHARGES		703, 330	0	/.
	Reasonabl e Charges				1
00	Routi ne servi ce charges		1, 207, 577		8.
00	Ancillary service charges		1, 454, 873	0	9.
. 00	Organ acquisition charges, net of revenue		0		10.
. 00	Incentive from target amount computation		0		11.
. 00	Total reasonable charges (sum of lines 8 through 11)		2, 662, 450	0	12.
. 00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.
. 00	basis	i services on a charge	0	0	15.
. 00	Amounts that would have been realized from patients liable for	r payment for services o	n 0	0	14.
	a charge basis had such payment been made in accordance with				
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	
. 00	Total customary charges (see instructions)		2, 662, 450	0	16.
. 00	Excess of customary charges over reasonable cost (complete onl	ly if line 16 exceeds	1, 756, 920	0	17.
. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete onl	ly if line 4 exceeds lin	0	0	18.
. 00	16) (see instructions)	Ty II IIIle 4 exceeds III	0	0	10.
. 00	Interns and Residents (see instructions)		0	0	19.
. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line	16)	905, 530	0	21.
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provi			
	Other than outlier payments		0	0	
. 00	Outlier payments		0	0	23.
. 00 . 00	Program capital payments		0		24. 25.
. 00	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	27.
	Customary charges (title V or XIX PPS covered services only)		0	0	
. 00	Titles V or XIX (sum of lines 21 and 27)		905, 530	0	29.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00	Excess of reasonable cost (from line 18)		0	0	30.
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	905, 530	0	
. 00	Deductibles		0	0	
. 00 . 00	Coinsurance Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0	0	35.
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	905, 530	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	<i>,</i>	0	0	37.
. 00	Subtotal (line 36 ± line 37)		905, 530	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39.
. 00	Total amount payable to the provider (sum of lines 38 and 39)		905, 530	0	40.
. 00	Interim payments		1, 076, 870	0	41
. 00	Balance due provider/program (line 40 minus line 41)		-171, 340	0	42.
. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2,	0	0	43.

ALANO	Financial Systems MAJOR HO E SHEET (If you are nonproprietary and do not maintain	Provi der	CCN: 150097	Peri od:	u of Form CMS- Worksheet G	
und-1	type accounting records, complete the General Fund column onl	у)		From 01/01/2015 To 12/31/2015		
		General Fund	Specific Purpose Func	Endowment Fund	4/28/2016 3:2 Plant Fund	
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS	F 000 000			0	1 1 0
00	Cash on hand in banks Temporary investments	5, 828, 892		0 0	0	
00	Notes receivable			0 0	0	
00	Accounts receivable	27, 715, 945		0 0	0	
00	Other receivable	0		0 0	0	5.0
00	Allowances for uncollectible notes and accounts receivable	-18, 761, 522		0 0	0	
00	Inventory	11, 298, 452		0 0	0	
00	Prepaid expenses Other current assets	1, 020, 480		0 0	0	
D. 00	Due from other funds	0 1, 020, 400		0 0	0	
1.00	Total current assets (sum of lines 1-10)	27, 102, 247		0 0	0	
	FI XED ASSETS					
2.00	Land	1, 978, 356		0 0	0	
3.00	Land improvements	6, 032, 222		0 0	0	
4.00 5.00	Accumulated depreciation Buildings	-2, 110, 875 89, 857, 581		0 0	0	1
5.00	Accumulated depreciation	-22, 924, 128		0 0	0	
7.00	Leasehold improvements	526, 503		0 0	0	1
3. 00	Accumul ated depreciation	-484, 349		0 0	0	18. C
9.00	Fixed equipment	868, 356		0 0	0	
0.00	Accumulated depreciation	-306, 856		0 0	0	
1.00	Automobiles and trucks Accumulated depreciation			0 0	0	
2.00 3.00	Major movable equipment	31, 136, 878		0 0	0	
4.00	Accumulated depreciation	-25, 613, 241		0 0	0	1
5.00	Minor equipment depreciable	0		0 0	0	25.0
5.00	Accumulated depreciation	0		0 0	0	
7.00	HIT designated Assets	0		0 0	0	
3.00	Accumulated depreciation	0		0 0	0	
7.00 0.00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	78, 960, 447		0 0	0	
5.00	OTHER ASSETS	10,700,117	1	0 0		00.0
1.00	Investments	0		0 0	0	31.0
2.00	Deposits on Leases	0		0 0	0	
3.00	Due from owners/officers	0		0 0	0	
4.00	Other assets	143, 886, 893		0 0	0	
5.00 5.00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	143, 886, 893 249, 949, 587		0 0	0	1
5. 00	CURRENT LI ABI LI TI ES	247, 747, 307		0 0	0	30.0
7.00	Accounts payable	3, 210, 864		0 0	0	37. C
3. 00	Salaries, wages, and fees payable	7, 472, 148		0 0	0	
	Payroll taxes payable	0		0 0	0	
	Notes and Loans payable (short term)	0		0 0	0	
1.00 2.00	Deferred income Accelerated payments			0 0	0	41.0
3.00	Due to other funds	0		0 0	0	
4.00	Other current liabilities	4, 572, 611		0 0	0	
5.00	Total current liabilities (sum of lines 37 thru 44)	15, 255, 623		0 0	0	45.0
	LONG TERM LIABILITIES	Γ	1			
5.00	Mortgage payable	0		0 0	0	
7.00 3.00	Notes payable Unsecured Loans			0 0	0	
<i>7.</i> 00	Other long term liabilities	79, 448, 239		0 0	0	
). 00	Total long term liabilities (sum of lines 46 thru 49	79, 448, 239		0 0	0	
1.00	Total liabilites (sum of lines 45 and 50)	94, 703, 862		0 0	0	
	CAPI TAL ACCOUNTS					
2.00	General fund balance	155, 245, 725				52.0
3.00	Specific purpose fund			0		53.0
4.00 5.00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. (55. (
5.00	Governing body created - endowment fund balance			0		56.
7.00	Plant fund balance - invested in plant			0	0	
3.00	Plant fund balance - reserve for plant improvement,				0	
_	replacement, and expansion					
9.00	Total fund balances (sum of lines 52 thru 58)	155, 245, 725		0 0	0	
D. 00	Total liabilities and fund balances (sum of lines 51 and	249, 949, 587		U 0	0	60.0

Heal th	Financial Systems	MAJOR HOS	SPI TAL			In Lie	eu of Form CMS-	2552-10
STATEN	ENT OF CHANGES IN FUND BALANCES		Provi de	er CCN: 150097		eriod: rom 01/01/2015 o 12/31/2015	Worksheet G- Date/Time Pr 4/28/2016 3:3	epared:
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fund	ł
		1.00	2.00	3.00		4.00	5.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)		118, 595, 7 36, 649, 9 155, 245, 7 155, 245, 7	71 25 0	0 0 0 0 0 0	0 0 0 0 0		5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total deductions (sum of lines 12–17) Fund balance at end of period per balance sheet (line 11 minus line 18)	Endowment Fund	155, 245, 7 PI a	0 25 nt Fund	000000000000000000000000000000000000000	0 0	() 14.00) 15.00) 16.00
		6.00	7.00	8.00				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0		0 0 0 0 0 0	0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0		0 0 0 0 0 0	0 0 0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

CTATE/	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Drovi dor	CCN: 150097	Do	ri od:	Worksheet G-2	2552-10
STATEN	ENT OF PATTENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 150097		om 01/01/2015	Parts & Date/Time Prep 4/28/2016 3:20	
	Cost Center Description	·	I npati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						
1 00	General Inpatient Routine Services		17,000,0			17 020 005	1 00
1.00 2.00	Hospital SUBPROVIDER - IPF		17, 038, 0	85		17, 038, 085	1.00 2.00
2.00	SUBPROVIDER - IRF			0		0	3.00
3.00 4.00	SUBPROVIDER			0		0	4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		Ő	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, 0	85		17, 038, 085	10.00
	Intensive Care Type Inpatient Hospital Services		1				
11.00	I NTENSI VE CARE UNI T		3, 950, 4	89		3, 950, 489	11.00
12.00	CORONARY CARE UNIT						12.00
13.00	BURN I NTENSI VE CARE UNI T						13.00
14.00 15.00	SURGI CAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						14. 00 15. 00
16.00	Total intensive care type inpatient hospital services (sum	oflinos	3, 950, 4	00		3, 950, 489	16.00
10.00	11-15)	UI ITTIES	3, 950, 4	07		3, 930, 469	10.00
17.00	Total inpatient routine care services (sum of lines 10 and	16)	20, 988, 5	74		20, 988, 574	17.00
18.00	Ancillary services		43, 597, 1		155, 717, 404	199, 314, 537	18.00
19.00	Outpatient services		6, 116, 5		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 27.00	HOSPI CE MI SC OTHER		2 025 4	FO	(000 2/5	0 004 004	26.00
27.00	Total patient revenues (sum of lines 17-27)(transfer column	2 to What	2, 935, 4 73, 637, 7		6, 089, 365 200, 485, 744	9, 024, 824 274, 123, 505	27.00 28.00
20.00	G-3. Line 1)	J LU WKSL.	/3,037,7	01	200, 405, 744	274, 123, 303	20.00
	PART II - OPERATING EXPENSES		L				
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 38.00	DEDUCT (SPECI FY)			0			37.00 38.00
38.00 39.00				0			38.00 39.00
40. 00				0			40.00
40.00				0			40.00
42.00	Total deductions (sum of lines 37-41)			Ŭ	o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer			86, 557, 748		43.00
	to Wkst. G-3, line 4)						

STATEME	NT OF REVENUES AND EXPENSES	Provi der	CCN: 150	7000			
					Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prep 4/28/2016 3:20	pared:
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,	line 28)				274, 123, 505	1.00
2.00 L	Less contractual allowances and discounts on patients' ac	counts				155, 294, 604	2.00
3.00	Net patient revenues (line 1 minus line 2)					118, 828, 901	3.00
4.00 L	Less total operating expenses (from Wkst. G-2, Part II, I	ine 43)				86, 557, 748	4.00
5.00 1	Net income from service to patients (line 3 minus line 4))				32, 271, 153	5.00
C	OTHER INCOME						
6.00	Contributions, donations, bequests, etc					0	6.00
7.00 I	Income from investments					0	7.00
	Revenues from telephone and other miscellaneous communica	ation services				0	8.00
9.00 F	Revenue from television and radio service					0	9.00
10.00 F	Purchase di scounts					0	10.00
11.00 F	Rebates and refunds of expenses					0	11.00
	Parking lot receipts					0	12.00
	Revenue from laundry and linen service					0	13.00
	Revenue from meals sold to employees and guests					0	14.00
	Revenue from rental of living quarters					0	15.00
	Revenue from sale of medical and surgical supplies to oth	ner than patients				0	16.00
	Revenue from sale of drugs to other than patients					0	17.00
	Revenue from sale of medical records and abstracts					0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)					0	19.00
	Revenue from gifts, flowers, coffee shops, and canteen					0	20.00
	Rental of vending machines					0	21.00
22.00 F	Rental of hospital space					0	22.00
	Governmental appropriations					0	23.00
24.00 0	OTHER REVENUE					2, 399, 969	24.00
	INVESTMENT INCOME					1, 146, 403	24.01
	TRANSFERS					2, 497, 463	24.02
	Total other income (sum of lines 6-24)					6, 043, 835	
	Total (line 5 plus line 25)					38, 314, 988	
	OTHER EXPENSES					1, 665, 017	
	Total other expenses (sum of line 27 and subscripts)					1, 665, 017	
29.00	Net income (or loss) for the period (line 26 minus line 2	28)				36, 649, 971	29.00

HHA CCN: 157418 F HHA CCN: 157418 T Image: Salaries Employee Benefits Transportation Contracted/Pur (see instructions) Image: Salaries Employee Benefits Transportation Image: Salaries Image: Salaries Salaries Image: Salaries Image: Salaries Services Image: Salaries Image: Salaries Image: Salaries Image: Salaries Image: Salaries Image: S	Home Health Agency I	4/28/2016 3:2 PPS Total (sum of col s. 1 thru 5) 6.00	
HHA CCN: 157418 T HHA CCN: 157418 T Sal ari es Empl oyee Benefits TransportationContracted/Pur (see chased instructions) Services 1.00 2.00 3.00 4.00 Capital Related - Bldg. & Fixtures O Capital Related - Movable O Equipment O O D O Capital Related - Movable 3.00 Plant Operation & Maintenance 0 0 0 0 3.00 Transportation 0 0 0 0	Fo 12/31/2015 Home Heal th Agency I Other Costs 5.00	4/28/2016 3:2 PPS Total (sum of col s. 1 thru 5) 6.00	
Benefits (see instructions) chased Services 1.00 2.00 3.00 4.00 GENERAL SERVICE COST CENTERS 1.00 2.00 3.00 4.00 GENERAL SERVICE COST CENTERS 2.00 Capital Related - Bldg. & Fixtures 0 2.00 Capital Related - Movable 0 Equipment 0 0 3.00 Plant Operation & Maintenance 0 4.00 Transportation 0 0	Agency I Other Costs 5.00	Total (sum of cols. 1 thru 5) 6.00	
Benefits(see instructions)chased Services1.002.003.004.00Capital Related - Bldg. & Fixtures2.00Capital Related - Movable0Equipment003.00Plant Operation & Maintenance0000000	0 Other Costs	col s. 1 thru 5) 6.00	
Benefits (see instructions) chased Services 1.00 2.00 3.00 4.00 GENERAL SERVICE COST CENTERS 1.00 2.00 3.00 4.00 Capital Related - Bldg. & Fixtures 2.00 Capital Related - Movable 0 Equipment 0 0 0 3.00 Plant Operation & Maintenance 0 0 0 4.00 Transportation 0 0 0	5.00	col s. 1 thru 5) 6.00	
instructions)Services1.002.003.004.00GENERAL SERVICE COST CENTERS1.00Capital Related - Bldg. & Fixtures02.00Capital Related - Movable0Equipment03.00Plant Operation & Maintenance04.00000000000	1	5) 6.00	
GENERAL SERVICE COST CENTERS 1.00 Capital Related - Bldg. & 0 Fixtures 0 0 2.00 Capital Related - Movable 0 Equipment 0 0 3.00 Plant Operation & Maintenance 0 0 0 4.00 Transportation 0 0 0 0	1		
1.00Capital Related - Bldg. & Fixtures02.00Capital Related - Movable Equipment03.00Plant Operation & Maintenance00004.00Transportation0	0		
Fixtures02.00Capital Related - Movable0Equipment003.00Plant Operation & Maintenance004.00Transportation000	0		1 1 00
2.00Capital Related - Movable0Equipment003.00Plant Operation & Maintenance0004.00Transportation000	0	0	1.00
Equipment3.00Plant Operation & Maintenance0004.00Transportation000	_	0	2.00
4.00 Transportation 0 0 0 0		-	
	0 0	0	3.00
	0 0	0	4.00
5.00 Administrative and General 134, 344 56, 548 0 C	190, 283	381, 175	5.00
HHA REIMBURSABLE SERVICES 6.00 Skilled Nursing Care 512,475 0 0 C	0 0	512, 475	6.00
7.00 Physical Therapy 98 0 0 294, 150	-	294, 248	
8.00 Occupational Therapy 63,237 0 0 0	0 0	63, 237	
9.00 Speech Pathology 549 0 0 0	0 0	549	
10.00 Medical Social Services 3,090 0 0 0	0	3,090	
11.00 Home Heal th Aide 57,325 0 0 0 0 12.00 Supplies (see instructions) 0	0	57, 325	
12.00 Supplies (see instructions) 0 <t< td=""><td></td><td></td><td></td></t<>			
14.00 DME 0 0 0			
HHA NONREI MBURSABLE SERVI CES	-		
15.00 Home Dialysis Aide Services 0 0 0 0	0 0	0	15.00
16.00 Respiratory Therapy 0 0 0 0 0	0 0	0	
17.00 Private Duty Nursing 0 0 0 10.00 Clinic 0 0 0	0	0	
18.00 Clinic 0 0 0 0 19.00 Health Promotion Activities 0 0 0 0 0			
20.00 Day Care Program 0 0 0 0			
21.00 Home Delivered Meals Program 0 0 0 0	0 0	0	21.00
22.00 Homemaker Service 0 0 0 0	0 0	0	22.00
23.00 All Others (specify) 0 0 0 0	0 0	0	23.00
24.00 Total (sum of lines 1-23) 771,118 56,548 0 294,150 Reclassificati Reclassified Adjustments Net Expenses	190, 283	1, 312, 099	24.00
on Trial Balance for Allocation	h		
(col. 6 + (col. 8 + col.			
col. 7) 9)	_		-
7.00 8.00 9.00 10.00			
GENERAL SERVICE COST CENTERS 1.00 Capital Related - Bldg. & 0 0 0 0 C			1.00
Fixtures			1.00
2.00 Capital Related - Movable 0 0 0 0	D		2.00
Equipment			0.07
3.00 Plant Operation & Maintenance 0 <			3.00
4.00 Transportation 0	7		4.00
HHA REIMBURSABLE SERVICES			1 0.00
6.00 Skilled Nursing Care 0 512, 475 0 512, 475	5		6.00
7.00 Physical Therapy 0 294, 248 0 294, 248			7.00
8.00 Occupational Therapy 0 63,237 0 63,237			8.00
9.00 Speech Pathology 0 549 0 549 10.00 Medical Social Services 0 3,090 0 3,090			9.00
10.00 Medical Social Services 0 3,090 0 3,090 11.00 Home Health Aide 0 57,325 0 57,325			10.00
12.00 Supplies (see instructions) 0 0 0 0			12.00
13.00 Drugs 0 0 0 0	D		13.00
14.00 DME 0 0 0			14.00
HHA NONREI MBURSABLE SERVI CES			15
15.00 Home Dialysis Aide Services 0 <t< td=""><td></td><td></td><td>15.00</td></t<>			15.00
17.00 Private Duty Nursing 0 0 0 0	5		17.00
18.00 Clinic 0 0 0			18.00
19.00 Health Promotion Activities 0 0 0 0	D		19.00
20.00 Day Care Program 0 0 0 0	כ		20.00
21.00 Home Delivered Meals Program 0 0 0 0			21.00
22.00 Homemaker Service 0 0 0 0 23.00 All Others (specify) 0 0 0 0			22.00 23.00
24.00 Total (sum of Lines 1-23) 0 1, 312, 099 -478 1, 311, 621	1		23.00
	1		

Heal th	Financial Systems		MAJOR HOS	SPI TAL		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - HHA GENERAL SERVICE	COST		Provi der HHA CCN:		Period: From 01/01/2015 To 12/31/2015	Worksheet H-1 Part I Date/Time Pre 4/28/2016 3:2	pared:
						Home Health	472872010 3.2 PPS	<u>o piii</u>
			Capital Rel	ated Costs		Agency I		
								_
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BIdgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportati on	Subtotal (cols. 0-4)	
	·	0	1.00	2.00	3.00	4.00	4A. 00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0				0	1.00
1.00	Fixtures		0				Ū	1.00
2.00	Capital Related – Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	0	3.00
4.00	Transportation	0	0	0		0 0	000 (07	4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	380, 697	0	0		0 0	380, 697	5.00
6.00	Skilled Nursing Care	512, 475	0	0		0 0	512, 475	
7.00 8.00	Physical Therapy Occupational Therapy	294, 248 63, 237	0	0		0 0	294, 248 63, 237	
8.00 9.00	Speech Pathol ogy	63, 237 549	0	0		0 0	63, 237 549	1
10.00	Medical Social Services	3, 090	0	0		0 0	3, 090	10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	57, 325 0	0	0		0 0	57, 325 0	1
13.00	Drugs	0	0	0		0	0	1
14.00	DME	0	0	0	1	0 0	0	14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0	[0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0	0	
17.00	Private Duty Nursing Clinic	0	0	0		0 0	0	
18.00 19.00	Health Promotion Activities	0	0	0		0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	20.00
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0	0	21.00
	All Others (specify)	0	0	0		0 0	0	1
24.00	Total (sum of lines 1-23)	1, 311, 621	0	0		0 0	1, 311, 621	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &							1.00
1.00	Fixtures							1.00
2.00	Capital Related – Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation	000 (07						4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	380, 697						5.00
6.00	Skilled Nursing Care	209, 574	722, 049					6.00
7.00 8.00	Physical Therapy Occupational Therapy	120, 331 25, 860	414, 579 89, 097					7.00 8.00
9.00	Speech Pathol ogy	23, 860	774					9.00
10.00	Medical Social Services	1, 264	4, 354					10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	23, 443	80, 768 0					11.00 12.00
13.00	Drugs	0	0					13.00
14.00	DME HHA NONREIMBURSABLE SERVICES	0	0					14.00
15.00	HOME Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00 18.00	Private Duty Nursing Clinic	0	0					17.00 18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0					21.00 22.00
23.00	All Others (specify)	0	0					23.00
24.00	Total (sum of lines 1-23)		1, 311, 621					24.00

Heal th	Financial Systems		MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HHA STATISTICAL BAS	SI S		Provider HHA CCN:	CCN: 150097 157418	Period: From 01/01/2015 To 12/31/2015	Worksheet H-1 Part II Date/Time Prep 4/28/2016 3:20	
						Home Health Agency I	PPS	
		Capital Re	ated Costs					
		· · · ·	Movable Equipment (DOLLAR VALUE)	Operation & Maintenance (SQUARE FEET)	(MI LEAGE)	onReconciliation	& General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	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	0	0	0		0		4.00
	instructions)							
5.00	Administrative and General	0	0	0		0 - 380, 697	930, 924	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	-		0 0	512, 475	6.00
7.00	Physical Therapy	0	0	0		0 0	294, 248	
8.00	Occupational Therapy	0	0	0		0 0	63, 237	8.00
9.00 10.00	Speech Pathology Medical Social Services		0	0		0 0	549 3, 090	
10.00	Home Health Aide		0	0		0 0	3, 090 57, 325	
12.00	Supplies (see instructions)		0	0		0 0	57, 325	12.00
13.00	Drugs		0	0		0	0	13.00
14.00	DME	0	0	0		0 0	0	
	HHA NONREI MBURSABLE SERVI CES		0					
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0	0	16.00
17.00	Private Duty Nursing	0	0	0		0 0	0	17.00
18.00	Clinic	0	0	0		0 0	0	18.00
19.00	Health Promotion Activities	0	0	0		0 0	0	19.00
20.00	Day Care Program	0	0	0		0 0	0	20.00
21.00	Home Delivered Meals Program	0	0	0		0 0	0	21.00
22.00	Homemaker Service	0	0	0		0 0	0	22.00
23.00	All Others (specify)	0	0	0		0 0	0	23.00
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	25.00
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0.0000	00	0. 408945	26.00

	Financial Systems		MAJOR HO				u of Form CMS-2	
ALLOCA	ATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider HHA CCN:		Period: From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
						Home Health	4/28/2016 3: 2 PPS	0 pm
			CAPI TAL			Agency I		
	Cost Center Description	HHA Trial Balance (1)	RELATED COSTS BLDG & FI XT	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ON		PURCHASI NG, RECEI VI NG, AND STORES	
		0	1.00	4.00	5.01	5. 02	5.03	
1.00 2.00	Administrative and General Skilled Nursing Care	0 722, 049	0	153, 025 0		0 74,696 0 0	8, 322 0	
3.00 4.00 5.00	Physical Therapy Occupational Therapy Speech Pathology	414, 579 89, 097 774	0 0	0			0 0 0	4.00
5.00 7.00	Medical Social Services Home Health Aide	4, 354 80, 768	0	0			0	6.00 7.00
8.00 9.00 10.00	Supplies (see instructions) Drugs DME	0 0 0	0 0 0	0 0 0		0 0 0 0	0 0 0	
1.00 2.00 3.00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	0	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	12.00
14.00 15.00 16.00	Clinic Health Promotion Activities Day Care Program	0	0	C C				14.00 15.00
7.00 8.00	Home Delivered Meals Program Homemaker Service	0	0 0 0	C			0	17. 0 18. 0
9.00 20.00 21.00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	0 1, 311, 621	0 0	0 153, 025		0 0 0 74,696	0 8, 322	
	6 decimal places. Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC OUNTS RECEI VABLE	Subtotal	OTHER ADMI NI STRATI VI AND GENERAL	OPERATION OF E PLANT	LAUNDRY & LINEN SERVICE	
		5.04	5. 05	5A. 05	5.06	7.00	8.00	
. 00	Administrative and General	12, 440 0	14, 925 0	263, 408			0	
. 00	Skilled Nursing Care Physical Therapy	0	0	722, 049 414, 579			0	
. 00	Occupational Therapy	0	0	89, 097			0	
. 00 . 00	Speech Pathology Medical Social Services	0	0	774 4, 354			0	
. 00	Home Health Aide	0	0	80, 768			0	7.0
. 00 . 00	Supplies (see instructions) Drugs	0	0	0		0 0	0	
0.00	5	0	0	0		0 0	0	
1. 00	Home Dialysis Aide Services	0	0	0		0 0	-	
2.00 3.00	Respiratory Therapy Private Duty Nursing	0	0	0			0	
4.00	5 5	0	0	C		0 0	0	
5.00	Health Promotion Activities	0	0	0		0 0	0	
6.00 7.00	Day Care Program Home Delivered Meals Program	0	0	0			0	
8.00	Ũ	0	0	0		0 0	0	
9.00	All Others (specify)	0	0	C		0 0	0	19.
0.00	Total (sum of lines 1-19) (2) 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.	12, 440	14, 925	1, 575, 029 0. 000000		2 0	0	20. (21. (

(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.

Health Financial Systems ALLOCATION OF GENERAL SERVIC	E COSTS T	O HHA COST CENT	FERS	Provi der HHA CCN:		Period: From 01/01/2015 To 12/31/2015		pared:
						Home Health	PPS	
Cost Center Desc	cription	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI C	Agency I CENTRAL N SERVI CES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
 Administrative and Ge Skilled Nursing Care O Skilled Nursing Care O Occupational Therapy O Scoupational Therapy O Speech Pathology O Home Heal th Aide O Drugs O DME O BME O Respiratory Therapy O Real th Promotion Activity O Home Dialysis Aide Se O Heal th Promotion Activity O Home Delivered Meals O All Others (specify) O O Total (sum of lines 1 O Unit Cost Multiplier: I ine 1 divided by of column 26, line 1, ro d decimal places. 	es tions) rvices vities Program -19) (2) column the sum minus					0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 15.00 16.00 17.00 18.00
Cost Center Desc	cription	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
 Administrative and Ge Skilled Nursing Care Skilled Nursing Care O Skilled Nursing Care O Ccupational Therapy O Scupational Therapy Supplies (see instruc O Drugs O DME O Home Heal th Aide O DHE O DME O Home Dialysis Aide Se O Private Duty Nursing O Halt th Promotion Active O Home Delivered Meals O Home Total (sum of lines 1 O Unit Cost Multiplier: I ine 1, roo column 26, line 1, roo 	es tions) rvices vities Program -19) (2) column the sum minus	14, 330 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	389, 913 807, 567 463, 680 99, 649 866 4, 870 90, 334 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		807, 56 463, 68 99, 64 86 4, 87 90, 33	$\begin{array}{cccccccccccccccccccccccccccccccccccc$	586, 924 126, 135 1, 096 6, 164 114, 344 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

(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.

Health Financial System			MAJOR HO					In Lie	u of Form CMS-2	
ALLOCATION OF GENERAL BASIS	SERVICE COSTS 1	FO HHA COST CEN	TERS STATISTIC		Provider HACCN:	CCN: 150097 157418	Period: From 01/ To 12/	01/2015 31/2015		pared:
							Home H Agenc		PPS	
		CAPI TAL					Agent	<u>, y 1</u>		
Cost Cente	er Description	RELATED COSTS BLDG & FI XT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)		I CATI ONS PHONES)	DATA PROCESSING (HARDWARE)	PURCHA RECEI VI STO (PURCH	NG, AND RES	ADMI TTI NG (GROSS CHARGES)	
		1.00	4.00		. 01	5.02		03	5.04	
1.00Administrative a2.00Skilled Nursing3.00Physical Therapy4.00Occupational The5.00Speech Pathology6.00Medical Social S7.00Home Health Aiddy8.00Supplies (see in9.00Drugs10.00DME11.00Home Dialysis Ai12.00Respiratory The13.00Private Duty Nut14.00Clinic15.00Health Promotion16.00Day Care Program17.00Home Delivered M18.00Homemaker Servic19.00All Others (spect20.00Total (sum of his21.00Total cost to ba22.00Unit cost multijCost Cente	Care y erapy Services e nstructions) ide Services rapy rsing n Activities m Meals Program ce cify) ines 1-19) e allocated	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	771, 118 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	74, 6'	67 0	41, 216 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12, 440	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
		OUNTS RECEI VABLE (GROSS CHARGES)		AND (AC	STRATI VE GENERAL CCUM. DST)	PLANT (SQUARE FEET)	(POUN LAUN		(SQUARE FEET)	
1.00 Administrative a	and General	5. 05 2, 182, 076	5A. 06	-	. 06 263, 408	7.00	0.8.	00	9.00	1.00
 2.00 Skilled Nursing 3.00 Physical Therap 4.00 Occupational The 5.00 Speech Pathology 6.00 Medical Social State 7.00 Home Health Aide 8.00 Supplies (see in 9.00 Drugs 10.00 DME 11.00 Home Dialysis Ai 12.00 Respiratory The 13.00 Private Duty Nui 14.00 Clinic 15.00 Health Promotion 16.00 Day Care Prograt 17.00 Home Delivered Masker Service 19.00 All Others (spect 20.00 Total (sum of litical sector) 	Care y erapy Services e nstructions) ide Services rapy rsing n Activities m Meals Program ce cify) ines 1-19) e allocated	2, 182, 078 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			203, 408 722, 049 414, 579 89, 097 774 4, 354 80, 768 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 20.00 21.00 21.00

Heal th	Financial Systems		MAJOR HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS STATISTIC	AL Provider	CCN: 150097	Peri od:	Worksheet H-2	
BASI S				HHA CCN:	157418	From 01/01/2015 To 12/31/2015		
						Home Health	PPS	
						Agency I		
	Cost Center Description	DIETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(PATI ENT	(MANHOURS)	ADMI NI STRATI ON		(100% DRUGS TO		
		DAYS)		(SUPPLY	PATI ENTS)	LI BRARY	
				(MANHOURS)	(100%		(GROSS	
		10.00	11.00	10.00	SUPPLIES)	15.00	CHARGES)	
1 00	Admini streetive and Consuma	10.00	11.00	13.00	14.00	15.00	16.00	1.00
1.00	Administrative and General	0	(25, 913		0 0	2, 182, 076	
2.00	Skilled Nursing Care	0	C	0		0 0	0	2.00
3.00	Physical Therapy	0	(0		0 0	0	3.00
4.00	Occupational Therapy	0	(0		0 0	0	4.00
5.00	Speech Pathol ogy	0	(0		0 0	0	5.00
6.00	Medical Social Services	0	(0		0 0	0	6.00
7.00	Home Health Aide	0	(0		0 0	0	7.00
8.00	Supplies (see instructions)	0	(0		0 0	0	8.00
9.00	Drugs	0	(0		0 0	0	9.00
10.00	DME	0	(0		0 0	0	10.00
11.00	Home Dialysis Aide Services	0	C	0		0 0	0	11.00
12.00	Respiratory Therapy	0	(0		0 0	0	12.00
13.00	Private Duty Nursing	0	(0		0 0	0	13.00
14.00	Clinic	0	(0		0 0	0	14.00
15.00	Health Promotion Activities	0	(0		0 0	0	15.00
16.00	Day Care Program	0	(0		0 0	0	16.00
17.00	Home Delivered Meals Program	0	(0		0 0	0	17.00
18.00	Homemaker Service	0	(0		0 0	0	18.00
19.00	All Others (specify)	0	(0		0 0	0	19.00
20.00	Total (sum of lines 1-19)	0	(25, 913		0	2, 182, 076	
21.00	Total cost to be allocated	0		80, 978			14, 330	
22.00	Unit cost multiplier	0. 000000	0. 000000	3. 124995	0.0000	0. 000000	0. 006567	22.00

Heal th	Financial Systems		MAJOR HO	SPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 150097	Peri od:	Worksheet H-3	
				HHA CCN:	157418	From 01/01/2015 To 12/31/2015		pared: O pm
				Ti t	le XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		(col. 3 ÷ col.	
		0	1.00	Part II) 2.00	3.00	4.00	4) 5.00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation		1		1		1	
1.00	Skilled Nursing Care	2.00			1, 022, 2			
2.00	Physical Therapy	3.00			586, 9			
3.00	Occupational Therapy	4.00			126, 1			
4.00	Speech Pathology Medical Social Services	5.00		(0 1,0			
5.00 6.00	Home Health Aide	6. 00 7. 00			6, 10 114, 34			
7.00	Total (sum of lines 1-6)	7.00	1, 856, 879		1, 856, 8			7.00
7.00			1,050,079		Program Visi			7.00
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					Deducti bl es			
					Coi nsurance	a		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation	I	T		1		1	
8.00	Skilled Nursing Care		26900			30		8.00
8.01	Skilled Nursing Care		50032		3,80			8.01
9.00	Physical Therapy		26900			23		9.00
9. 01 10. 00	Physical Therapy Occupational Therapy		50032 26900		2, 19	53		9.01 10.00
10.00	Occupational Therapy		50032			94		10.00
11.00	Speech Pathol ogy		26900		5 4	4		11.00
11.00	Speech Pathology		50032		-	13		11.00
12.00	Medical Social Services		26900			2		12.00
12.00	Medical Social Services		50032			47		12.00
13.00	Home Health Aide		26900	(59		13.00
13.01	Home Health Aide		50032	(0 1, 10			13.01
14.00	Total (sum of lines 8-13)			(0 8, 5	52		14.00
	Cost Center Description	From Wkst. H-2	Facility Costs	Shared	Total HHA	Total Charges	Ratio (col. 3	
		Part I, col.	(from Wkst.	Ancillary	Costs (cols.		÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Record)		
		-	1.00	Part II)	2.00	4.00	F 00	
	Supplies and Drugs Cost Compute	0 ations	1.00	2.00	3.00	4.00	5.00	
15.00	Cost of Medical Supplies	8.00	0	(b	0 0	0. 000000	15 00
16.00	Cost of Drugs	9.00			0	0 0		
10100		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Program Visits		Cost of		0100000	10100
			····g······		Servi ces			
			Par	tВ	1	Part B		
	Cost Center Description	Part A	Not Subject to	Subject to	Part A	Not Subject to		
			Deductibles &	Deductibles &		Deductibles &	Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	YKUGRAM CUST, A	GGREGATE OF H	HE PROGRAM LIN	MITATION COST, O	ĸ	
	Cost Per Visit Computation	1	1		1	_	1	
1.00	Skilled Nursing Care	0				0 812, 270		1.00
2.00	Physical Therapy	0				0 458, 118		2.00
3.00	Occupational Therapy	0				0 93, 362		3.00
4.00	Speech Pathol ogy	0				0 1,433		4.00
5.00	Medical Social Services	0				0 4, 315		5.00
6.00 7.00	Home Health Aide Total (sum of lines 1-6)	0				0 107, 988 0 1, 477, 486		6.00 7.00
		0	0,002		1	J 1, 477, 400	1	1 1.00

	Financial Systems IONMENT OF PATIENT SERVICE COST	-s	MAJOR HO		CCN: 150097	Peri od:	u of Form CMS- Worksheet H-3	
	TONMENT OF FAILENT SERVICE COST	5		HHA CCN:	157418	From 01/01/2015	Part I Date/Time Pre 4/28/2016 3:2	pared
				Ti tl	e XVIII	Home Health Agency I	PPS	<u>o piii</u>
	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation	0.00	7.00	0.00	7.00	10.00	11.00	
3.00 3.01 3.01 9.00 9.01 10.00 10.01 11.01 12.00 12.01 13.00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide							8. (8. (9. (9. (10. (11. (11. (12. (12. (13. (
13.00	Home Health Aide							13.0
14.00	Total (sum of lines 8-13)							14.0
		Prog	ram Covered Cha	rges	Cost of Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to	Part A	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 Comput							
5.00	Cost of Medical Supplies	0	-	0		0 0	C	
6.00	Cost of Drugs		0	0		0	C	16.0
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						-
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	ROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	!	
	BENEFICIARY COST LIMITATION							-
00	Cost Per Visit Computation	010.070	[1
. 00 2. 00	Skilled Nursing Care Physical Therapy	812, 270 458, 118						1.0
. 00	Occupational Therapy	93, 362						3.
ł. 00	Speech Pathology	1, 433						4.0
5.00	Medical Social Services	4, 315						5.0
. 00	Home Health Aide	107, 988						6.
	Total (sum of lines 1-6)	1, 477, 486						7.(
. 00	Cost Center Description					-		-
. 00		12 00	1					
. 00	Limitation Cost Computation	12.00						
	Limitation Cost Computation Skilled Nursing Care	12.00						8.
. 00	Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care	12.00						8. 8.
. 00 . 01 . 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy	12.00						8. 9.
. 00 . 01 . 00 . 01	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy	12.00						8. 9. 9.
8. 00 8. 01 9. 00 9. 01 0. 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy	12.00						8. 9. 9. 10.
3. 00 3. 01 9. 00 9. 01 0. 00 0. 01	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy	12.00						8. 9. 9. 10. 10.
3. 00 3. 01 9. 00 9. 01 0. 00 0. 01 1. 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology	12.00						8. 9. 9. 10. 10. 11.
3. 00 3. 01 9. 00 9. 01 10. 00 10. 01 11. 00 11. 01	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology	12.00						8. 9. 10. 10. 11. 11.
3. 00 3. 01 9. 00 9. 01 10. 00 10. 01 11. 00 11. 01 12. 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology	12.00						8. 9. 10. 10. 11. 11. 12.
7.00 8.00 3.01 9.00 9.01 10.00 10.01 11.00 11.01 12.00 12.01 13.00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services	12.00						8. 9. 9. 10.
3. 00 3. 01 7. 00 7. 01 10. 00 10. 01 11. 00 11. 01 12. 00 12. 01	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide	12.00						8. 9. 10. 10. 11. 11. 12. 12.

Health Financial Systems		MAJOR HO	SPI TAL	_		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COSTS				Provi der	CCN: 150097	Period: From 01/01/2015	Worksheet H-3 Part II	
				HHA CCN:	157418			
				Ti tl	e XVIII	Home Health	PPS	
						Agency I		
Cost Center Description	From Wkst. C,	Cost to Charge	Tot	al HHA	HHA Shared	Transfer to		
	Part I, col.	Ratio	Charg	ge (from	Ancillary	Part I as		
	9, line		pro	ovi der	Costs (col.	1 Indicated		
			red	cords)	x col. 2)			
	0	1.00		2.00	3.00	4.00		
PART II - APPORTIONMENT OF COS	T OF HHA SERVIC	CES FURNI SHED B	BY SHAF	RED HOSPI	TAL DEPARTMEN	NTS	•	
1.00 Physical Therapy	66.00	0. 434406		0	I	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 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 328263		0		0 col. 2, line 1	6. 00	5.00
						,		

Heal th	Financial Systems MAJOR HOSPITA	L		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150097	Peri od:	Worksheet H-4	
		HHA CCN:	157418	From 01/01/2015 To 12/31/2015		
		Ti tl	e XVIII	Home Health	PPS	•
				Agency I Par	t B	
			Part A	Not Subject to		
					Deductibles &	
				Coi nsurance	Coi nsurance	
			1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMA	RY CHARGE	S			
1 00	Reasonable Cost of Part A & Part B Services		1	0	0	1 00
1.00 2.00	Reasonable cost of services (see instructions)			0 0 0 0		1.00 2.00
2.00	Total charges Customary Charges			0 0	0	2.00
3.00	Amount actually collected from patients liable for payment for s	ervi ces		0 0	0	3.00
0.00	on a charge basis (from your records)			с - С	0	0,00
4.00	Amount that would have been realized from patients liable for pa	yment		0 0	0	4.00
	for services on a charge basis had such payment been made in acc	ordance				
	with 42 CFR §413.13(b)					
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	-		5.00
6.00	Total customary charges (see instructions)	malata			0	6.00
7.00	Excess of total customary charges over total reasonable cost (cc only if line 6 exceeds line 1)	mprete		0 0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only	ifline		0 0	0	8.00
0.00	1 exceeds line 6)			0	0	0.00
9.00	Primary payer amounts			0 0	0	9.00
				Part A	Part B	
				Servi ces	Servi ces	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00	
10.00	Total reasonable cost (see instructions)			0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers			0		
12.00	Total PPS Reimbursement - Full Episodes with Outliers			0	84, 260	
13.00	Total PPS Reimbursement - LUPA Episodes			0	10, 989	13.00
14.00	Total PPS Reimbursement - PEP Episodes			0	2, 490	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	21, 854	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes			0	0	16.00
17.00	Total Other Payments			0	0	17.00
18.00	DME Payments			0	0	18.00
19.00	Oxygen Payments			0	0	19.00 20.00
20. 00 21. 00	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura	(nco)		0	0	20.00
21.00	Subtotal (sum of lines 10 thru 20 minus line 21)	ince)		0		
23.00	Excess reasonable cost (from line 8)			0		23.00
24.00	Subtotal (line 22 minus line 23)			0	-	
25.00	Coinsurance billed to program patients (from your records)			-	0	25.00
26.00	Net cost (line 24 minus line 25)			0	1, 221, 499	26.00
27.00	Reimbursable bad debts (from your records)					27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see inst	ructions))			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 2	27)		0		
30.00	OTHER			0		30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0		30.50
31.00	Subtotal (see instructions)			0		
31.01	Sequestration adjustment (see instructions)			0		
32.00 33.00	Interim payments (see instructions) Tentative settlement (for contractor use only)			0		32.00 33.00
33.00 34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and	33)		0		34.00
35.00	Protested amounts (nonallowable cost report items) in accordance	,	S Pub. 15-2.	0		35.00
	chapter 1, §115.2		1			

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO		TO P	TAL Provider CCN: 150097		Peri od:		u of Form CMS-2552- Worksheet H-5	
PROGRAM BENEFICIARIES		н	HA CCN:	157418	Fro To	om 01/01/2015 12/31/2015	Date/Time Prep 4/28/2016 3:20	barec
					ŀ	Home Health Agency I	PPS	5 pin
			npati en	t Part A		Par	t B	
	-		l/yyyy	Amount		mm/dd/yyyy	Amount	
		1.	00	2.00		3.00	4.00	
00 00	Total interim payments paid to provider 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		1, 197, 070 0	1. 2.
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) Program to Provider							3.
01					0		0	3.
02					0		0	3.
03					0		0	3.
04					0		0	3.
05					0		0	3
	Provider to Program							
0					0		0	3
51					0		0	3
52					0		0	3
53					0		0	3
54					0		0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0		0	3
0	3.50-3.98)				0		1 107 070	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
	TO BE COMPLETED BY CONTRACTOR							
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
	Program to Provider							
)1					0		0	5
)2					0		0	5
)3					0		0	5
	Provider to Program							
0					0		0	5
51					0		0	5
52					0		0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				0		0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)							6
)1	SETTLEMENT TO PROVIDER				0		0	6
)2	SETTLEMENT TO PROGRAM				0		0	6
00	Total Medicare program liability (see instructions)				0		1, 197, 070	7
						Contractor Number	NPR Date (Mo/Day/Yr)	
			()		1.00	2.00	

Health Financial Systems MAJO	R HOSPI TAL	In Lie	u of Form CMS-2	2552-		
CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150097	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prep 4/28/2016 3:20			
	Title XVIII	Hospi tal	PPS			
			1.00			
PART I - FULLY PROSPECTIVE METHOD			1.00			
CAPITAL FEDERAL AMOUNT				1		
.00 Capital DRG other than outlier			667, 835	1.		
.01 Model 4 BPCI Capital DRG other than outlier			0	1.		
2.00 Capital DRG outlier payments			481	2. 2.		
2.01 Model 4 BPCI Capital DRG outlier payments						
3.00 Total inpatient days divided by number of days in the c	ost reporting period (see inst	ructions)	28.72	3.		
1.00 Number of interns & residents (see instructions)	`		0.00			
5.00 Indirect medical education percentage (see instructions 5.00 Indirect medical education adjustment (multiply line 5		columno 1 and	0.00	5. 6.		
6.00 Indirect medical education adjustment (multiply line 5 1.01) (see instructions)	by the sum of times I and I. Of	, corumns rand	0	0.		
7.00 Percentage of SSI recipient patient days to Medicare Pa	rt A patient davs (Worksheet F	. part A line	0.00	7.		
30) (see instructions)		, pare // /////	0.00			
B. 00 Percentage of Medicaid patient days to total days (see	0.00	8.				
0.00 Sum of lines 7 and 8	0.00	9.				
	00 Allowable disproportionate share percentage (see instructions)					
1.00 Disproportionate share adjustment (see instructions)			0			
2.00 Total prospective capital payments (see instructions)			668, 316	12.		
			1.00			
PART II - PAYMENT UNDER REASONABLE COST			1100			
.00 Program inpatient routine capital cost (see instruction	is)		0	1.		
2.00 Program inpatient ancillary capital cost (see instructi			0	2.		
3.00 Total inpatient program capital cost (line 1 plus line	2)		0	3.		
4.00 Capital cost payment factor (see instructions)			0	4.		
5.00 Total inpatient program capital cost (line 3 x line 4)			0	5.		
			1.00			
PART III - COMPUTATION OF EXCEPTION PAYMENTS						
.00 Program inpatient capital costs (see instructions)			0	1.		
. 00 Program inpatient capital costs for extraordinary circu			0	2.		
.00 Net program inpatient capital costs (line 1 minus line .00 Applicable exception percentage (see instructions)	2)		0 0.00	3. 4.		
. 00 Capital cost for comparison to payments (line 3 x line	4)		0.00			
0.00 Percentage adjustment for extraordinary circumstances (0.00			
		line 6)	0.00	7.		
	dinary circumstances (line 2 x					
.00 Adjustment to capital minimum payment level for extraor	dinary circumstances (line 2 x		0			
7.00 Adjustment to capital minimum payment level for extraor 8.00 Capital minimum payment level (line 5 plus line 7)	3		0 0	9.		
.00 Adjustment to capital minimum payment level for extraor .00 Capital minimum payment level (line 5 plus line 7) .00 Current year capital payments (from Part I, line 12, as	appl i cabl e)					
 .00 Adjustment to capital minimum payment level for extraor .00 Capital minimum payment level (line 5 plus line 7) .00 Current year capital payments (from Part I, line 12, as 0.00 Current year comparison of capital minimum payment level 	applicable) I to capital payments (line 8	less line 9)	0			
 Adjustment to capital minimum payment level for extraor Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital 	applicable) to capital payments (line 8 over capital payment (from pri tal payments (line 10 plus lin	less line 9) or year e 11)	0	10. 11. 12.		
 Adjustment to capital minimum payment level for extraor Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level Curryover of accumulated capital minimum payment level Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capi Out current year exception payment (if line 12 is positive, 	applicable) I to capital payments (line 8 over capital payment (from pri tal payments (line 10 plus lin enter the amount on this line	less line 9) or year e 11))	0 0 0	10. 11. 12. 13.		
 Adjustment to capital minimum payment level for extraor Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level Curryover of accumulated capital minimum payment level Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capi Current year exception payment (if line 12 is positive, 	applicable) I to capital payments (line 8 over capital payment (from pri tal payments (line 10 plus lin enter the amount on this line over capital payment for the f	less line 9) or year e 11))	0 0 0	10. 11. 12. 13.		
 Adjustment to capital minimum payment level for extraor Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capi Current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level to carryover of accumulated capital minimum payment level Net comparison of capital minimum payment level to capi Current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this line) 	applicable) I to capital payments (line 8 over capital payment (from pri tal payments (line 10 plus lin enter the amount on this line over capital payment for the f	less line 9) or year e 11))	0 0 0 0 0	10. 11. 12. 13. 14.		
 Adjustment to capital minimum payment level for extraor Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capi Current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level to carryover of accumulated capital minimum payment level Net comparison of capital minimum payment level to capi Current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this line) 	applicable) I to capital payments (line 8 over capital payment (from pri tal payments (line 10 plus lin enter the amount on this line over capital payment for the f eee instructions) ons)	less line 9) or year e 11))	0 0 0 0 0	10. 11. 12. 13. 14. 15. 16.		