This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 153030	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/25/2016 12:52 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/25/2016 Time: 12:52 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REHABILITATION HOSPITAL OF FT WAYNE (153030) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	5,023	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	5,023	0	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2016 2:53 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 7970 WEST JEFFERSON BOULEVARD	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46804-	County: ALLEN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	REHABILITATION HOSPITAL OF FT WAYNE	153030	23060	5	11/01/1993	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2014	09/30/2015	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	610	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2016 2:53 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2016 2:53 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2016 2:53 pm

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	8,936	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2016 2:53 pm

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 10301	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 153030	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/23/2016 2:53 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2016 2:53 pm

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	01/29/2016	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 2/23/2016 2:53 pm

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2014	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BRITTNI	KING	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-2769	BRITTNI_KING@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2016 2:53 pm

		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)	01/29/2016			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		SENIOR REVENUE MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/23/2016 2:53 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	36	13,140	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		36	13,140	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
10.00	BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		36	13,140	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
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)		36				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2016 2:53 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,353	610	5,333			1.00
2.00	HMO and other (see instructions)	773	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	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)	2,353	610	5,333			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT	0	0	0			9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	2,353	610	5,333	0.00	82.64	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	82.64	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2016 2:53 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	212	46	492	1.00
2.00	HMO and other (see instructions)			66	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	212	46	492	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/23/2016 2:53 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		277,838	277,838	205,077	482,915	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		177,428	177,428	74,554	251,982	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	123,470	27,071	150,541	784,716	935,257	4.00
5.01	00570	ADMITTING	269,047	390,858	659,905	-206	659,699	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	375,574	2,037,666	2,413,240	-1,525,445	887,795	5.02
7.00	00700	OPERATION OF PLANT	194,284	417,872	612,156	-3,552	608,604	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	31,522	31,522	0	31,522	8.00
9.00	00900	HOUSEKEEPING	81,642	21,576	103,218	-43	103,175	9.00
10.00	01000	DIETARY	275,759	192,836	468,595	-312,081	156,514	10.00
11.00	01100	CAFETERIA	0	0	0	311,016	311,016	11.00
13.00	01300	NURSING ADMINISTRATION	252,846	22,139	274,985	-118	274,867	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	7,450	78,351	85,801	-53,340	32,461	14.00
15.00	01500	PHARMACY	92,864	201,786	294,650	-191,451	103,199	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	154,115	58,448	212,563	-2,648	209,915	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,613,457	216,417	1,829,874	427,481	2,257,355	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,095	14,095	0	14,095	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	28,560	35,119	63,679	0	63,679	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	3,771	11,228	14,999	-10,417	4,582	65.00
66.00	06600	PHYSICAL THERAPY	479,185	54,090	533,275	-1,638	531,637	66.00
67.00	06700	OCCUPATIONAL THERAPY	630,685	60,065	690,750	0	690,750	67.00
68.00	06800	SPEECH PATHOLOGY	220,914	25,723	246,637	-4	246,633	68.00
69.00	06900	ELECTROCARDIOLOGY	406	3,035	3,441	0	3,441	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,250	11,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	183,791	183,791	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	41,579	6,034	47,613	-26	47,587	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	35,030	35,030	0	35,030	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,845,608	4,396,227	9,241,835	-103,084	9,138,751	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	141	3,353	3,494	-86	3,408	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	0	0	0	103,170	103,170	194.00
194.01	07951	TENANT LEASED SPACE	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	4,845,749	4,399,580	9,245,329	0	9,245,329	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/23/2016 2:53 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	137,996	620,911		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-74,030	177,952		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	935,257		4.00
5.01	00570	ADMITTING	-303,471	356,228		5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	126,445	1,014,240		5.02
7.00	00700	OPERATION OF PLANT	-4,852	603,752		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,679	37,201		8.00
9.00	00900	HOUSEKEEPING	0	103,175		9.00
10.00	01000	DIETARY	0	156,514		10.00
11.00	01100	CAFETERIA	-67,683	243,333		11.00
13.00	01300	NURSING ADMINISTRATION	0	274,867		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	-21,335	11,126		14.00
15.00	01500	PHARMACY	0	103,199		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-30	209,885		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-160,176	2,097,179		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
32.00	03200	CORONARY CARE UNIT	0	0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0		34.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,095		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	63,679		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	4,582		65.00
66.00	06600	PHYSICAL THERAPY	0	531,637		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	690,750		67.00
68.00	06800	SPEECH PATHOLOGY	0	246,633		68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,441		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,250		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	183,791		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	47,587		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	35,030		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-361,457	8,777,294		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,408		192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	0	103,170		194.00
194.01	07951	TENANT LEASED SPACE	0	0		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-361,457	8,883,872		200.00

RECLASSIFICATIONS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/23/2016 2:53 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	784,973		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		0	784,973		
	B - RENTAL AND LEASE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	74,554		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
	0		0	74,554		
	C - OTHER CAPITAL COSTS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	18,095		1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	186,982		2.00
	0		0	205,077		
	D - MARKETING					
1.00	MARKETING/PUBLIC RELATIONS	194.00	86,048	17,122		1.00
	0		86,048	17,122		
	E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,739		1.00
	0		0	10,739		
	F - PHYSICIAN DIRECTORS					
1.00	ADULTS & PEDIATRICS	30.00	0	427,709		1.00
	0		0	427,709		
	G - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	183,791		1.00
	0		0	183,791		
	H - DIETARY					
1.00	CAFETERIA	11.00	183,444	127,572		1.00
	0		183,444	127,572		
	I - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	511		1.00
	0		0	511		
500.00	Grand Total: Increases		269,492	1,832,048		500.00

RECLASSIFICATIONS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/23/2016 2:53 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	784,711	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	45	0		2.00
3.00	HOUSEKEEPING	9.00	0	43	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	174	0		4.00
	0		0	784,973			
	B - RENTAL AND LEASE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	257	9		1.00
2.00	ADMITTING	5.01	0	206	0		2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	4,778	0		3.00
4.00	OPERATION OF PLANT	7.00	0	3,552	0		4.00
6.00	DIETARY	10.00	0	1,065	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	118	0		7.00
8.00	CENTRAL SERVICE & SUPPLY	14.00	0	42,601	0		8.00
9.00	PHARMACY	15.00	0	7,660	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,648	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	54	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	9,906	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	1,593	0		13.00
14.00	SPEECH PATHOLOGY	68.00	0	4	0		14.00
15.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	26	0		15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	86	0		16.00
	0		0	74,554			
	C - OTHER CAPITAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	18,095	12		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	186,982	13		2.00
	0		0	205,077			
	D - MARKETING						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	86,048	17,122	0		1.00
	0		86,048	17,122			
	E - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	10,739	0		1.00
	0		0	10,739			
	F - PHYSICIAN DIRECTORS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	427,709	0		1.00
	0		0	427,709			
	G - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	183,791	0		1.00
	0		0	183,791			
	H - DIETARY						
1.00	DIETARY	10.00	183,444	127,572	0		1.00
	0		183,444	127,572			
	I - OXYGEN COSTS						
1.00	RESPIRATORY THERAPY	65.00	0	511	0		1.00
	0		0	511			
500.00	Grand Total: Decreases		269,492	1,832,048			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 2/23/2016 2:53 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	900,000	0	0	0	0	1.00
2.00	Land Improvements	276,744	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,841,265	158,949	0	158,949	104,910	3.00
4.00	Building Improvements	659,206	52,138	0	52,138	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	8,135	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,685,350	211,087	0	211,087	104,910	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	13,685,350	211,087	0	211,087	104,910	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	900,000	0	1.00
2.00	Land Improvements	276,744	0	2.00
3.00	Buildings and Fixtures	11,895,304	0	3.00
4.00	Building Improvements	711,344	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	8,135	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,791,527	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	13,791,527	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 2/23/2016 2:53 pm

	Cost Center Description	SUMMARY OF CAPITAL: Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	277,838	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	177,428	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	455,266	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	277,838				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	177,428				2.00
3.00	Total (sum of lines 1-2)	0	455,266				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 2/23/2016 2:53 pm

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

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	315,810	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	177,952	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	493,762	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	100,024	18,095	186,982	0	620,911	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	177,952	2.00
3.00	Total (sum of lines 1-2)	100,024	18,095	186,982	0	798,863	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/23/2016 2:53 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-160,176			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	241,197			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-67,683	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-12,538	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-30	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-892	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	A	47,806	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	A	-89,877	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/23/2016 2:53 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELANEOUS INCOME	B	-575	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.00
33.02	BAD DEBT EXPENSE	A	-307,043	ADMITTING	5.01	0	33.02
33.03	PATIENT TELEPHONE EXPENSE	A	-4,678	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.03
33.06	PATIENT TV CABLE EXPENSE	A	-4,852	OPERATION OF PLANT	7.00	0	33.06
33.07	CHARITABLE CONTRIBUTIONS	A	-1,705	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.07
33.09	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-411	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-361,457				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 2/23/2016 2:53 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	DIRECT ALLOCATION - INTEREST	100,024	0	1.00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIX	PASI CAPITAL COSTS - BLDG &	782	0	2.00
3.00	1.00	NEW CAP REL COSTS-BLDG & FIX	BUILDING AND FIXTURES	1,922	0	3.00
4.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	MOVABLE EQUIPMENT	12,797	0	4.00
4.01	5.02	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	184,080	0	4.01
4.02	5.02	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE ALLOCATIONS	8,936	90,000	4.02
4.03	8.00	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICE	37,201	31,522	4.03
4.04	2.00	NEW CAP REL COSTS-MVBLE EQUI	PASI CAPITAL COSTS - MOVEABL	3,050	0	4.04
4.05	5.01	ADMITTING	PASI OPERATING COSTS	4,148	0	4.05
4.06	5.01	ADMITTING	PASI COLLECTION FEES	0	484	4.06
4.07	5.01	ADMITTING	EBOS FEES	0	79	4.07
4.08	5.01	ADMITTING	PASI LIEN UNIT COLLECTION FE	0	13	4.08
4.09	14.00	CENTRAL SERVICE & SUPPLY	HOSPITAL LAUNDRY SERVICE	0	21,335	4.09
4.10	5.02	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL ALLOCATIONS	31,690	0	4.10
5.00	0		0	384,630	143,433	5.00

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

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

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

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

6.00	B		0.00	COMMUNITY HEALT	100.00	6.00
7.00	B		0.00	LUTHERAN	0.00	7.00
8.00	G	HOSPITAL LAUNDR	0.00	LAUNDRY	0.00	8.00
9.00	B		0.00	PASI	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	NON-FINANCIAL				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 2/23/2016 2:53 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	100,024	11		1.00
2.00	782	9		2.00
3.00	1,922	9		3.00
4.00	12,797	9		4.00
4.01	184,080	0		4.01
4.02	-81,064	0		4.02
4.03	5,679	0		4.03
4.04	3,050	9		4.04
4.05	4,148	0		4.05
4.06	-484	0		4.06
4.07	-79	0		4.07
4.08	-13	0		4.08
4.09	-21,335	0		4.09
4.10	31,690	0		4.10
5.00	241,197			5.00

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

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

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

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

6.00	HEALTHCARE		6.00
7.00	HOSPITAL		7.00
8.00	CONSOL LAUNDRY		8.00
9.00	DEBT COLLECTION		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 2/23/2016 2:53 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	160,176	160,176	0	136,700	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			160,176	160,176	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	160,176		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	160,176		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/23/2016 2:53 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS: NEW BLDG & FIXT	CAPITAL RELATED COSTS: NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	620,911	620,911				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	177,952		177,952			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	935,257	2,505	884	938,646		4.00
5.01	00570	ADMITTING	356,228	12,902	4,553	53,478	427,161	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	1,014,240	48,867	17,246	57,549	0	5.02
7.00	00700	OPERATION OF PLANT	603,752	113,744	40,145	38,618	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	37,201	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	103,175	12,288	4,337	16,228	0	9.00
10.00	01000	DIETARY	156,514	0	0	18,349	0	10.00
11.00	01100	CAFETERIA	243,333	47,477	16,755	36,463	0	11.00
13.00	01300	NURSING ADMINISTRATION	274,867	1,329	469	50,258	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	11,126	9,385	3,312	1,481	0	14.00
15.00	01500	PHARMACY	103,199	3,977	1,403	18,459	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	209,885	4,560	1,609	30,633	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,955	1,043	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,097,179	79,057	27,900	320,705	150,419	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,095	4,396	1,551	0	8,204	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	63,679	0	0	5,677	16,534	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	4,582	1,022	361	750	1,604	65.00
66.00	06600	PHYSICAL THERAPY	531,637	103,163	36,408	95,248	68,817	66.00
67.00	06700	OCCUPATIONAL THERAPY	690,750	48,704	17,188	125,361	72,986	67.00
68.00	06800	SPEECH PATHOLOGY	246,633	3,691	1,302	43,911	32,085	68.00
69.00	06900	ELECTROCARDIOLOGY	3,441	0	0	81	656	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,250	0	0	0	10,995	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	183,791	0	0	0	55,345	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	47,587	4,212	1,486	8,265	5,621	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	35,030	0	0	0	3,895	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,777,294	504,234	177,952	921,514	427,161	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,408	0	0	28	0	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	103,170	0	0	17,104	0	194.00
194.01	07951	TENANT LEASED SPACE	0	116,677	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,883,872	620,911	177,952	938,646	427,161	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/23/2016 2:53 pm

		Cost Center Description	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	1,137,902	1,137,902				5.02
7.00	00700	OPERATION OF PLANT	796,259	116,972	913,231			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	37,201	5,465	0	42,666		8.00
9.00	00900	HOUSEKEEPING	136,028	19,983	25,338	0	181,349	9.00
10.00	01000	DIETARY	174,863	25,688	0	0	0	10.00
11.00	01100	CAFETERIA	344,028	50,538	97,896	0	27,426	11.00
13.00	01300	NURSING ADMINISTRATION	326,923	48,026	2,740	0	768	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	25,304	3,717	19,352	0	5,422	14.00
15.00	01500	PHARMACY	127,038	18,662	8,200	0	2,297	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	246,687	36,239	9,402	0	2,634	16.00
17.00	01700	SOCIAL SERVICE	3,998	587	6,092	0	1,707	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,675,260	393,005	163,012	23,933	45,669	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,246	4,149	9,064	0	2,539	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	85,890	12,617	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	8,319	1,222	2,108	0	591	65.00
66.00	06600	PHYSICAL THERAPY	835,273	122,703	212,719	8,884	59,596	66.00
67.00	06700	OCCUPATIONAL THERAPY	954,989	140,290	100,425	9,849	28,135	67.00
68.00	06800	SPEECH PATHOLOGY	327,622	48,128	7,610	0	2,132	68.00
69.00	06900	ELECTROCARDIOLOGY	4,178	614	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,245	3,268	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	239,136	35,130	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	67,171	9,868	8,685	0	2,433	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	38,925	5,718	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,643,485	1,102,589	672,643	42,666	181,349	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,436	505	0	0	0	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	120,274	17,668	0	0	0	194.00
194.01	07951	TENANT LEASED SPACE	116,677	17,140	240,588	0	0	194.01
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,883,872	1,137,902	913,231	42,666	181,349	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/23/2016 2:53 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	200,551					10.00
11.00	01100	CAFETERIA	0	519,888				11.00
13.00	01300	NURSING ADMINISTRATION	0	28,883	407,340			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	53,795		14.00
15.00	01500	PHARMACY	0	9,628	0	0	165,825	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,255	0	989	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	200,551	279,198	407,340	38,613	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	9,628	0	114	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	134	0	65.00
66.00	06600	PHYSICAL THERAPY	0	67,393	0	1,653	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	77,020	0	1,627	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	28,883	0	99	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,681	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	165,825	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,178	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	200,551	519,888	407,340	51,088	165,825	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	33	0	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	0	0	0	2,674	0	194.00
194.01	07951	TENANT LEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	200,551	519,888	407,340	53,795	165,825	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/23/2016 2:53 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	315,206					16.00
17.00	01700	SOCIAL SERVICE	0	12,384				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	110,995	12,384	4,349,960	0	4,349,960	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,054	0	50,052	0	50,052	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	12,201	0	120,450	0	120,450	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,183	0	13,557	0	13,557	65.00
66.00	06600	PHYSICAL THERAPY	50,781	0	1,359,002	0	1,359,002	66.00
67.00	06700	OCCUPATIONAL THERAPY	53,857	0	1,366,192	0	1,366,192	67.00
68.00	06800	SPEECH PATHOLOGY	23,676	0	438,150	0	438,150	68.00
69.00	06900	ELECTROCARDIOLOGY	484	0	5,276	0	5,276	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,113	0	40,307	0	40,307	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,840	0	480,931	0	480,931	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,148	0	93,483	0	93,483	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	2,874	0	47,517	0	47,517	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	315,206	12,384	8,364,877	0	8,364,877	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,974	0	3,974	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	0	0	140,616	0	140,616	194.00
194.01	07951	TENANT LEASED SPACE	0	0	374,405	0	374,405	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	315,206	12,384	8,883,872	0	8,883,872	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/23/2016 2:53 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,505	884	3,389	3,389	4.00
5.01	00570	ADMITTING	0	12,902	4,553	17,455	193	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	48,867	17,246	66,113	208	5.02
7.00	00700	OPERATION OF PLANT	0	113,744	40,145	153,889	139	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	12,288	4,337	16,625	59	9.00
10.00	01000	DIETARY	0	0	0	0	66	10.00
11.00	01100	CAFETERIA	0	47,477	16,755	64,232	132	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,329	469	1,798	182	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	9,385	3,312	12,697	5	14.00
15.00	01500	PHARMACY	0	3,977	1,403	5,380	67	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,560	1,609	6,169	111	16.00
17.00	01700	SOCIAL SERVICE	0	2,955	1,043	3,998	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	79,057	27,900	106,957	1,155	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,396	1,551	5,947	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	21	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	1,022	361	1,383	3	65.00
66.00	06600	PHYSICAL THERAPY	0	103,163	36,408	139,571	344	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	48,704	17,188	65,892	453	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,691	1,302	4,993	159	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	4,212	1,486	5,698	30	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	504,234	177,952	682,186	3,327	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	0	0	0	0	62	194.00
194.01	07951	TENANT LEASED SPACE	0	116,677	0	116,677	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	620,911	177,952	798,863	3,389	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/23/2016 2:53 pm

		Cost Center Description	ADMITTING	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	17,648					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	66,321				5.02
7.00	00700	OPERATION OF PLANT	0	6,818	160,846			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	319	0	319		8.00
9.00	00900	HOUSEKEEPING	0	1,165	4,463	0	22,312	9.00
10.00	01000	DIETARY	0	1,497	0	0	0	10.00
11.00	01100	CAFETERIA	0	2,946	17,242	0	3,374	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,799	483	0	94	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	217	3,408	0	667	14.00
15.00	01500	PHARMACY	0	1,088	1,444	0	283	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,112	1,656	0	324	16.00
17.00	01700	SOCIAL SERVICE	0	34	1,073	0	210	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,218	22,905	28,711	179	5,619	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	339	242	1,597	0	312	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	683	735	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	66	71	371	0	73	65.00
66.00	06600	PHYSICAL THERAPY	2,842	7,152	37,466	66	7,333	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,015	8,177	17,688	74	3,462	67.00
68.00	06800	SPEECH PATHOLOGY	1,325	2,805	1,340	0	262	68.00
69.00	06900	ELECTROCARDIOLOGY	27	36	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	454	190	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,286	2,047	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	232	575	1,530	0	299	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	161	333	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,648	64,263	118,472	319	22,312	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	29	0	0	0	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	0	1,030	0	0	0	194.00
194.01	07951	TENANT LEASED SPACE	0	999	42,374	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	17,648	66,321	160,846	319	22,312	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/23/2016 2:53 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,563					10.00
11.00	01100	CAFETERIA	0	87,926				11.00
13.00	01300	NURSING ADMINISTRATION	0	4,885	10,241			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	16,994		14.00
15.00	01500	PHARMACY	0	1,628	0	0	9,890	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,257	0	313	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,563	47,219	10,241	12,198	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	1,628	0	36	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	42	0	65.00
66.00	06600	PHYSICAL THERAPY	0	11,398	0	522	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13,026	0	514	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,885	0	31	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,110	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	9,890	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	372	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,563	87,926	10,241	16,138	9,890	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	11	0	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	0	0	0	845	0	194.00
194.01	07951	TENANT LEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,563	87,926	10,241	16,994	9,890	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/23/2016 2:53 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,942					16.00
17.00	01700	SOCIAL SERVICE	0	5,315				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,903	5,315	253,183	0	253,183	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	268	0	8,705	0	8,705	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	540	0	3,643	0	3,643	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	52	0	2,061	0	2,061	65.00
66.00	06600	PHYSICAL THERAPY	2,248	0	208,942	0	208,942	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,384	0	114,685	0	114,685	67.00
68.00	06800	SPEECH PATHOLOGY	1,048	0	16,848	0	16,848	68.00
69.00	06900	ELECTROCARDIOLOGY	21	0	84	0	84	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	359	0	3,113	0	3,113	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,808	0	16,031	0	16,031	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	184	0	8,920	0	8,920	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	127	0	621	0	621	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,942	5,315	636,836	0	636,836	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	40	0	40	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	0	0	1,937	0	1,937	194.00
194.01	07951	TENANT LEASED SPACE	0	0	160,050	0	160,050	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	13,942	5,315	798,863	0	798,863	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 2:53 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	728,820					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		591,864				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,940	2,940	4,722,279			4.00
5.01	00570	ADMITTING	15,144	15,144	269,047	22,649,476		5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	57,360	57,360	289,526	0	-1,137,902	5.02
7.00	00700	OPERATION OF PLANT	133,512	133,512	194,284	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	14,424	14,424	81,642	0	0	9.00
10.00	01000	DIETARY	0	0	92,315	0	0	10.00
11.00	01100	CAFETERIA	55,728	55,728	183,444	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,560	1,560	252,846	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	11,016	11,016	7,450	0	0	14.00
15.00	01500	PHARMACY	4,668	4,668	92,864	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,352	5,352	154,115	0	0	16.00
17.00	01700	SOCIAL SERVICE	3,468	3,468	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	92,796	92,796	1,613,457	7,975,976	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,160	5,160	0	434,988	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	28,560	876,674	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,200	1,200	3,771	85,034	0	65.00
66.00	06600	PHYSICAL THERAPY	121,092	121,092	479,185	3,648,854	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,168	57,168	630,685	3,869,898	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,332	4,332	220,914	1,701,229	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	406	34,762	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	582,963	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,934,525	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,944	4,944	41,579	298,032	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	206,541	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	591,864	591,864	4,636,090	22,649,476	-1,137,902	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	141	0	0	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	0	0	86,048	0	0	194.00
194.01	07951	TENANT LEASED SPACE	136,956	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	620,911	177,952	938,646	427,161		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.851940	0.300664	0.198770	0.018860		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,389	17,648		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000718	0.000779		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 2:53 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.02	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	7,745,970					5.02
7.00	00700	OPERATION OF PLANT	796,259	519,864				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	37,201	0	60,626			8.00
9.00	00900	HOUSEKEEPING	136,028	14,424	0	368,484		9.00
10.00	01000	DIETARY	174,863	0	0	0	33,896	10.00
11.00	01100	CAFETERIA	344,028	55,728	0	55,728	0	11.00
13.00	01300	NURSING ADMINISTRATION	326,923	1,560	0	1,560	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	25,304	11,016	0	11,016	0	14.00
15.00	01500	PHARMACY	127,038	4,668	0	4,668	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	246,687	5,352	0	5,352	0	16.00
17.00	01700	SOCIAL SERVICE	3,998	3,468	0	3,468	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,675,260	92,796	34,007	92,796	33,896	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,246	5,160	0	5,160	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	85,890	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	8,319	1,200	0	1,200	0	65.00
66.00	06600	PHYSICAL THERAPY	835,273	121,092	12,624	121,092	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	954,989	57,168	13,995	57,168	0	67.00
68.00	06800	SPEECH PATHOLOGY	327,622	4,332	0	4,332	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,178	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,245	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	239,136	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	67,171	4,944	0	4,944	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	38,925	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,505,583	382,908	60,626	368,484	33,896	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,436	0	0	0	0	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	120,274	0	0	0	0	194.00
194.01	07951	TENANT LEASED SPACE	116,677	136,956	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,137,902	913,231	42,666	181,349	200,551	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.146902	1.756673	0.703757	0.492149	5.916657	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	66,321	160,846	319	22,312	1,563	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.008562	0.309400	0.005262	0.060551	0.046112	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 2:53 pm

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES-NURS AREAS)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	54					11.00
13.00	01300	NURSING ADMINISTRATION	3	29				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	90,591			14.00
15.00	01500	PHARMACY	1	0	0	183,794		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2	0	1,666	0	22,649,476	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29	29	65,023	0	7,975,976	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	434,988	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1	0	192	0	876,674	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	226	0	85,034	65.00
66.00	06600	PHYSICAL THERAPY	7	0	2,784	0	3,648,854	66.00
67.00	06700	OCCUPATIONAL THERAPY	8	0	2,740	0	3,869,898	67.00
68.00	06800	SPEECH PATHOLOGY	3	0	167	0	1,701,229	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	34,762	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	11,250	0	582,963	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	183,794	2,934,525	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	1,984	0	298,032	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	206,541	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	54	29	86,032	183,794	22,649,476	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	56	0	0	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	0	0	4,503	0	0	194.00
194.01	07951	TENANT LEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	519,888	407,340	53,795	165,825	315,206	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9,627.555556	14,046.206897	0.593823	0.902233	0.013917	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	87,926	10,241	16,994	9,890	13,942	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,628.259259	353.137931	0.187590	0.053810	0.000616	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 2:53 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS %)	
			17.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL		5.02
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	100	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	100	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
32.00	03200	CORONARY CARE UNIT	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
		OTHER REIMBURSABLE COST CENTERS		
99.10	09910	CORF	0	99.10
		SPECIAL PURPOSE COST CENTERS		
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	0	194.00
194.01	07951	TENANT LEASED SPACE	0	194.01
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	12,384	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	123.840000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,315	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	53.150000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,349,960		4,349,960	0	4,349,960	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0		0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,052		50,052	0	50,052	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	120,450		120,450	0	120,450	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	13,557	0	13,557	0	13,557	65.00
66.00	06600	PHYSICAL THERAPY	1,359,002	0	1,359,002	0	1,359,002	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,366,192	0	1,366,192	0	1,366,192	67.00
68.00	06800	SPEECH PATHOLOGY	438,150	0	438,150	0	438,150	68.00
69.00	06900	ELECTROCARDIOLOGY	5,276		5,276	0	5,276	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,307		40,307	0	40,307	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	480,931		480,931	0	480,931	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	93,483		93,483	0	93,483	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	47,517		47,517	0	47,517	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	8,364,877	0	8,364,877	0	8,364,877	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	8,364,877	0	8,364,877	0	8,364,877	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,975,976		7,975,976			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
32.00	03200	CORONARY CARE UNIT	0		0			32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	434,468	520	434,988	0.115065	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	876,674	0	876,674	0.137394	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	84,131	903	85,034	0.159430	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,648,854	0	3,648,854	0.372446	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,869,898	0	3,869,898	0.353030	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,701,229	0	1,701,229	0.257549	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	34,762	0	34,762	0.151775	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	579,814	3,149	582,963	0.069142	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,924,201	10,324	2,934,525	0.163887	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	298,032	0	298,032	0.313668	0.000000	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	197,119	9,422	206,541	0.230061	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,625,158	24,318	22,649,476			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,625,158	24,318	22,649,476			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 2:53 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
32.00	03200	CORONARY CARE UNIT		32.00
33.00	03300	BURN INTENSIVE CARE UNIT		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.115065	54.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.137394	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.159430	65.00
66.00	06600	PHYSICAL THERAPY	0.372446	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.353030	67.00
68.00	06800	SPEECH PATHOLOGY	0.257549	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151775	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.069142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163887	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.313668	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.230061	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
		OTHER REIMBURSABLE COST CENTERS		
99.10	09910	CORF		99.10
		SPECIAL PURPOSE COST CENTERS		
109.00	10900	PANCREAS ACQUISITION		109.00
110.00	11000	INTESTINAL ACQUISITION		110.00
111.00	11100	ISLET ACQUISITION		111.00
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 2:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,349,960		4,349,960	0	4,349,960	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0		0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,052		50,052	0	50,052	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	120,450		120,450	0	120,450	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	13,557	0	13,557	0	13,557	65.00
66.00	06600	PHYSICAL THERAPY	1,359,002	0	1,359,002	0	1,359,002	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,366,192	0	1,366,192	0	1,366,192	67.00
68.00	06800	SPEECH PATHOLOGY	438,150	0	438,150	0	438,150	68.00
69.00	06900	ELECTROCARDIOLOGY	5,276		5,276	0	5,276	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,307		40,307	0	40,307	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	480,931		480,931	0	480,931	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	93,483		93,483	0	93,483	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	47,517		47,517	0	47,517	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	8,364,877	0	8,364,877	0	8,364,877	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	8,364,877	0	8,364,877	0	8,364,877	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 2:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,975,976		7,975,976			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
32.00	03200	CORONARY CARE UNIT	0		0			32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	434,468	520	434,988	0.115065	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	876,674	0	876,674	0.137394	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	84,131	903	85,034	0.159430	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,648,854	0	3,648,854	0.372446	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,869,898	0	3,869,898	0.353030	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,701,229	0	1,701,229	0.257549	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	34,762	0	34,762	0.151775	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	579,814	3,149	582,963	0.069142	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,924,201	10,324	2,934,525	0.163887	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	298,032	0	298,032	0.313668	0.000000	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	197,119	9,422	206,541	0.230061	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,625,158	24,318	22,649,476			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,625,158	24,318	22,649,476			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 2:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
32.00	03200	CORONARY CARE UNIT			32.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.115065		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.137394		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.159430		65.00
66.00	06600	PHYSICAL THERAPY	0.372446		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.353030		67.00
68.00	06800	SPEECH PATHOLOGY	0.257549		68.00
69.00	06900	ELECTROCARDIOLOGY	0.151775		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.069142		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163887		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.313668		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.230061		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
		SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part II Date/Time Prepared: 2/23/2016 2:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,052	8,705	41,347	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	120,450	3,643	116,807	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	13,557	2,061	11,496	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,359,002	208,942	1,150,060	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,366,192	114,685	1,251,507	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	438,150	16,848	421,302	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,276	84	5,192	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,307	3,113	37,194	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	480,931	16,031	464,900	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	93,483	8,920	84,563	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	47,517	621	46,896	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	4,014,917	383,653	3,631,264	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	4,014,917	383,653	3,631,264	0	0	202.00

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

Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part II Date/Time Prepared: 2/23/2016 2:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,052	434,988	0.115065		54.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000	LABORATORY	120,450	876,674	0.137394		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	13,557	85,034	0.159430		65.00
66.00	06600	PHYSICAL THERAPY	1,359,002	3,648,854	0.372446		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,366,192	3,869,898	0.353030		67.00
68.00	06800	SPEECH PATHOLOGY	438,150	1,701,229	0.257549		68.00
69.00	06900	ELECTROCARDIOLOGY	5,276	34,762	0.151775		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,307	582,963	0.069142		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	480,931	2,934,525	0.163887		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	93,483	298,032	0.313668		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	47,517	206,541	0.230061		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	0.000000		99.10
		SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	0.000000		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0.000000		110.00
111.00	11100	ISLET ACQUISITION	0	0	0.000000		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	4,014,917	14,673,500			200.00
201.00		Less Observation Beds	0	0			201.00
202.00		Total (line 200 minus line 201)	4,014,917	14,673,500			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part I Date/Time Prepared: 2/23/2016 2:53 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	253,183	0	253,183	5,333	47.47	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	0		0	0	0.00	43.00
200.00	Total (lines 30-199)	253,183		253,183	5,333		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,353	111,697	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
32.00	CORONARY CARE UNIT	0	0	32.00
33.00	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	2,353	111,697	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/23/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,705	434,988	0.020012	188,496	3,772	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	3,643	876,674	0.004155	391,862	1,628	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,061	85,034	0.024237	25,878	627	65.00
66.00	06600	PHYSICAL THERAPY	208,942	3,648,854	0.057262	1,628,692	93,262	66.00
67.00	06700	OCCUPATIONAL THERAPY	114,685	3,869,898	0.029635	1,701,657	50,429	67.00
68.00	06800	SPEECH PATHOLOGY	16,848	1,701,229	0.009903	745,181	7,380	68.00
69.00	06900	ELECTROCARDIOLOGY	84	34,762	0.002416	19,678	48	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,113	582,963	0.005340	243,359	1,300	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,031	2,934,525	0.005463	1,225,528	6,695	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,920	298,032	0.029930	135,848	4,066	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	621	206,541	0.003007	110,586	333	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
200.00		Total (lines 50-199)	383,653	14,673,500		6,416,765	169,540	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part III Date/Time Prepared: 2/23/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0		0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,333	0.00	2,353	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
32.00	03200	CORONARY CARE UNIT	0	0.00	0	0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0.00	0	0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0.00	0	0		34.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	0	0.00	0	0		43.00
200.00		Total (lines 30-199)	5,333		2,353	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/23/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	434,988	0.000000	0.000000	188,496	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	876,674	0.000000	0.000000	391,862	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	85,034	0.000000	0.000000	25,878	65.00
66.00	06600	PHYSICAL THERAPY	0	3,648,854	0.000000	0.000000	1,628,692	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,869,898	0.000000	0.000000	1,701,657	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,701,229	0.000000	0.000000	745,181	68.00
69.00	06900	ELECTROCARDIOLOGY	0	34,762	0.000000	0.000000	19,678	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	582,963	0.000000	0.000000	243,359	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,934,525	0.000000	0.000000	1,225,528	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	298,032	0.000000	0.000000	135,848	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	206,541	0.000000	0.000000	110,586	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
200.00		Total (lines 50-199)	0	14,673,500			6,416,765	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/23/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	520	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	903	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,149	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,324	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	9,422	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
200.00		Total (lines 50-199)	0	24,318	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/23/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.115065	520	0	0	60	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.137394	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.159430	903	0	0	144	65.00
66.00	06600	PHYSICAL THERAPY	0.372446	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.353030	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.257549	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151775	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.069142	3,149	0	0	218	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163887	10,324	0	0	1,692	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.313668	0	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.230061	9,422	0	0	2,168	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
200.00		Subtotal (see instructions)		24,318	0	0	4,282	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		24,318	0	0	4,282	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/23/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part I Date/Time Prepared: 2/23/2016 2:53 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	253,183	0	253,183	5,333	47.47	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	0		0	0	0.00	43.00
200.00	Total (lines 30-199)	253,183		253,183	5,333		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	610	28,957	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
32.00	CORONARY CARE UNIT	0	0	32.00
33.00	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	610	28,957	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/23/2016 2:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,705	434,988	0.020012	36,918	739	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	3,643	876,674	0.004155	63,948	266	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,061	85,034	0.024237	4,576	111	65.00
66.00	06600	PHYSICAL THERAPY	208,942	3,648,854	0.057262	208,619	11,946	66.00
67.00	06700	OCCUPATIONAL THERAPY	114,685	3,869,898	0.029635	215,576	6,389	67.00
68.00	06800	SPEECH PATHOLOGY	16,848	1,701,229	0.009903	62,577	620	68.00
69.00	06900	ELECTROCARDIOLOGY	84	34,762	0.002416	1,304	3	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,113	582,963	0.005340	64,758	346	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,031	2,934,525	0.005463	171,908	939	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,920	298,032	0.029930	10,347	310	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	621	206,541	0.003007	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
200.00		Total (lines 50-199)	383,653	14,673,500		840,531	21,669	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part III Date/Time Prepared: 2/23/2016 2:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0		0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,333	0.00	610	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
32.00	03200	CORONARY CARE UNIT	0	0.00	0	0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0.00	0	0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0.00	0	0		34.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	0	0.00	0	0		43.00
200.00		Total (lines 30-199)	5,333		610	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 2:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/23/2016 2:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	434,988	0.000000	0.000000	36,918	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	876,674	0.000000	0.000000	63,948	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	85,034	0.000000	0.000000	4,576	65.00
66.00	06600	PHYSICAL THERAPY	0	3,648,854	0.000000	0.000000	208,619	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,869,898	0.000000	0.000000	215,576	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,701,229	0.000000	0.000000	62,577	68.00
69.00	06900	ELECTROCARDIOLOGY	0	34,762	0.000000	0.000000	1,304	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	582,963	0.000000	0.000000	64,758	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,934,525	0.000000	0.000000	171,908	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	298,032	0.000000	0.000000	10,347	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	206,541	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
200.00		Total (lines 50-199)	0	14,673,500			840,531	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 2:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 2:53 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,333	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,333	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	5,177	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	156	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,353	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,349,960	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,349,960	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	7,975,976	28.00
29.00	Private room charges (excluding swing-bed charges)	7,743,526	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	232,450	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.545383	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	1,495.76	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,490.06	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	5.70	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	3.11	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	16,100	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,333,860	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	815.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,919,272	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,919,272	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 2:53 pm

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,767,625	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,686,897	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	111,697	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	169,540	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	281,237	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,405,660	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 2:53 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	253,183	4,349,960	0.058204	0	0	90.00
91.00	Nursing School cost	0	4,349,960	0.000000	0	0	91.00
92.00	Allied health cost	0	4,349,960	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,349,960	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 2:53 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,333	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,333	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,333	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	610	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,349,960	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,349,960	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,349,960	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	815.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	497,559	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	497,559	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 2:53 pm

Title XIX | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	219,779	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	717,338	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	28,957	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	21,669	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	50,626	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	666,712	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 2:53 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	253,183	4,349,960	0.058204	0	0	90.00
91.00	Nursing School cost	0	4,349,960	0.000000	0	0	91.00
92.00	Allied health cost	0	4,349,960	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,349,960	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/23/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,517,799		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
32.00	03200	CORONARY CARE UNIT		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0		34.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.115065	188,496	21,689	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.137394	391,862	53,839	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.159430	25,878	4,126	65.00
66.00	06600	PHYSICAL THERAPY	0.372446	1,628,692	606,600	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.353030	1,701,657	600,736	67.00
68.00	06800	SPEECH PATHOLOGY	0.257549	745,181	191,921	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151775	19,678	2,987	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.069142	243,359	16,826	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163887	1,225,528	200,848	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.313668	135,848	42,611	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.230061	110,586	25,442	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
200.00		Total (sum of lines 50-94 and 96-98)		6,416,765	1,767,625	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		6,416,765		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/23/2016 2:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		418,310		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
32.00	03200	CORONARY CARE UNIT		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0		34.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.115065	36,918	4,248	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.137394	63,948	8,786	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.159430	4,576	730	65.00
66.00	06600	PHYSICAL THERAPY	0.372446	208,619	77,699	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.353030	215,576	76,105	67.00
68.00	06800	SPEECH PATHOLOGY	0.257549	62,577	16,117	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151775	1,304	198	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.069142	64,758	4,477	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163887	171,908	28,173	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.313668	10,347	3,246	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.230061	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
200.00		Total (sum of lines 50-94 and 96-98)		840,531	219,779	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		840,531		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 153030	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/23/2016 2:53 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,282	2.00
3.00	PPS payments	4,030	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	4,030	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	806	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,224	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,224	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	3,224	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	3,224	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,224	40.00
40.01	Sequestration adjustment (see instructions)	64	40.01
41.00	Interim payments	3,160	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2016 2:53 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,562,476		3,160	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,562,476		3,160	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		5,023		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,567,499		3,160	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 153030	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part III Date/Time Prepared: 2/23/2016 2:53 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	3,408,780	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0226	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	141,805	3.00
4.00	Outlier Payments	127,842	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	14.610959	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	3,678,427	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	3,678,427	17.00
18.00	Primary payer payments	217	18.00
19.00	Subtotal (line 17 less line 18).	3,678,210	19.00
20.00	Deductibles	31,324	20.00
21.00	Subtotal (line 19 minus line 20)	3,646,886	21.00
22.00	Coinsurance	8,190	22.00
23.00	Subtotal (line 21 minus line 22)	3,638,696	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	2,476	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	1,609	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,476	26.00
27.00	Subtotal (sum of lines 23 and 25)	3,640,305	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	3,640,305	32.00
32.01	Sequestration adjustment (see instructions)	72,806	32.01
33.00	Interim payments	3,562,476	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	5,023	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	81,811	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	127,842	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-3 Part VII Date/Time Prepared: 2/23/2016 2:53 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	418,310		8.00
9.00	Ancillary service charges	840,531	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,258,841	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,258,841	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,258,841	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G | Date/Time Prepared: 2/23/2016 2:53 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	513	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,676,861	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-246,792	0	0	0	6.00
7.00	Inventory	32,738	0	0	0	7.00
8.00	Prepaid expenses	31,876	0	0	0	8.00
9.00	Other current assets	784	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,495,980	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	900,000	0	0	0	12.00
13.00	Land improvements	276,453	0	0	0	13.00
14.00	Accumulated depreciation	-108,121	0	0	0	14.00
15.00	Buildings	11,624,396	0	0	0	15.00
16.00	Accumulated depreciation	-2,029,493	0	0	0	16.00
17.00	Leasehold improvements	235,036	0	0	0	17.00
18.00	Accumulated depreciation	-62,688	0	0	0	18.00
19.00	Fixed equipment	137,158	0	0	0	19.00
20.00	Accumulated depreciation	-45,232	0	0	0	20.00
21.00	Automobiles and trucks	113,428	0	0	0	21.00
22.00	Accumulated depreciation	-79,616	0	0	0	22.00
23.00	Major movable equipment	199,137	0	0	0	23.00
24.00	Accumulated depreciation	-124,146	0	0	0	24.00
25.00	Minor equipment depreciable	305,919	0	0	0	25.00
26.00	Accumulated depreciation	-233,101	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,109,130	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	691,701	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	691,701	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	13,296,811	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	145,625	0	0	0	37.00
38.00	Salaries, wages, and fees payable	517,282	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	15,889,854	0	0	0	43.00
44.00	Other current liabilities	252,271	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	16,805,032	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	16,805,032	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-3,508,221				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-3,508,221	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	13,296,811	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-1 | Date/Time Prepared: 2/23/2016 2:53 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		18,712,903		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,399,417				2.00
3.00	Total (sum of line 1 and line 2)		17,313,486		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		17,313,486		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		17,313,486		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/23/2016 2:53 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,975,976		7,975,976	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,975,976		7,975,976	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,975,976		7,975,976	17.00
18.00	Ancillary services	14,649,179	0	14,649,179	18.00
19.00	Outpatient services	0	24,318	24,318	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	22,625,155	24,318	22,649,473	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		9,245,329		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		9,245,329		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 153030 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-3 | Date/Time Prepared: 2/23/2016 2:53 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	22,649,473	1.00
2.00	Less contractual allowances and discounts on patients' accounts	14,885,279	2.00
3.00	Net patient revenues (line 1 minus line 2)	7,764,194	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	9,245,329	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,481,135	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	67,683	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	30	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	892	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	13,113	24.00
25.00	Total other income (sum of lines 6-24)	81,718	25.00
26.00	Total (line 5 plus line 25)	-1,399,417	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,399,417	29.00