

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet S Parts I-III Date/Time Prepared: 7/31/2015 9:03 am
--	----------------------	---------------------------------------	---

**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 7/31/2015 Time: 9:03 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by KOSCIUSKO COMMUNITY HOSPITAL ( 150133 ) for the cost reporting period beginning 03/01/2014 and ending 02/28/2015 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 XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-58,606	-116,466	14,905	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
8.00 NURSING FACILITY	0				0	8.00
200.00 Total	0	-58,606	-116,466	14,905	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 150133		Period: From 03/01/2014 To 02/28/2015		Worksheet S-2 Part I Date/Time Prepared: 7/30/2015 3:14 pm									
1.00		2.00		3.00		4.00											
Hospital and Hospital Health Care Complex Address:																	
1.00	Street: 2101 EAST DUBOIS DRIVE			PO Box:				1.00									
2.00	City: WARSAW		State: IN		Zip Code: 46580-		County: KOSCIUSKO			2.00							
Component Name																	
Component Identification:																	
1.00																	
2.00																	
3.00																	
4.00																	
5.00																	
6.00																	
7.00																	
8.00																	
9.00																	
10.00																	
11.00																	
12.00																	
13.00																	
14.00																	
15.00																	
16.00																	
17.00																	
18.00																	
19.00																	
3.00	Hospital			KOSCIUSKO COMMUNITY HOSPITAL		150133		99915		1	07/01/1966	0	P	0	3.00		
4.00	Subprovider - IPF														4.00		
5.00	Subprovider - IRF														5.00		
6.00	Subprovider - (Other)														6.00		
7.00	Swing Beds - SNF														7.00		
8.00	Swing Beds - NF														8.00		
9.00	Hospital-Based SNF														9.00		
10.00	Hospital-Based NF														10.00		
11.00	Hospital-Based OLTC														11.00		
12.00	Hospital-Based HHA														12.00		
13.00	Separately Certified ASC														13.00		
14.00	Hospital-Based Hospice														14.00		
15.00	Hospital-Based Health Clinic - RHC														15.00		
16.00	Hospital-Based Health Clinic - FQHC														16.00		
17.00	Hospital-Based (CMHC) I														17.00		
18.00	Renal Dialysis														18.00		
19.00	Other														19.00		
											From:		To:				
											1.00		2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)										03/01/2014		02/28/2015		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.										Y	N	22.00				
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)										N	Y	22.01				
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.										N	N	22.02				
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.										N	N	22.03				
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.										3	N	23.00				
											In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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.										610	202	0	2	1,204	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 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.										0	0	0	0	0	25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet S-2 Part I Date/Time Prepared: 7/30/2015 3:14 pm		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for 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)(iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00
		V	XVII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
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
<b>Teaching Hospitals</b>						
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, § 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
61.01	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: 150133		Period: From 03/01/2014 To 02/28/2015		Worksheet S-2 Part I Date/Time Prepared: 7/30/2015 3:14 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		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet S-2 Part I Date/Time Prepared: 7/30/2015 3:14 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
<b>Inpatient Psychiatric Facility PPS</b>						
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, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)				0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)				0	76.00
				1.00		
<b>Long Term Care Hospital PPS</b>						
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
<b>TEFRA Providers</b>						
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150133		Period: From 03/01/2014 To 02/28/2015		Worksheet S-2 Part I Date/Time Prepared: 7/30/2015 3:14 pm	
		V		XIX			
		1.00		2.00			
<b>Title V and XIX Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y			90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N			91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N			92.00
93.00	Does this facility operate an ICF/MR 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
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
<b>Rural Providers</b>							
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	Column 1: 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 would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	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
		<b>Physical</b>		<b>Occupational</b>		<b>Speech</b>	
		1.00		2.00		3.00	
						<b>Respiratory</b>	
						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	
<b>Miscellaneous Cost Reporting Information</b>							
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, §2208.1.	N			0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00
		<b>Premiums</b>		<b>Losses</b>		<b>Insurance</b>	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	13,067		332,178		0	
						1.00	
						2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N					118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N			120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y					121.00
<b>Transplant Center Information</b>							
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150133		Period: From 03/01/2014 To 02/28/2015		Worksheet S-2 Part I Date/Time Prepared: 7/30/2015 3:14 pm	
		1.00	2.00				
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	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008			140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS		Contractor's Number: 08001		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	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.			N		145.00	
						1.00	
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, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	N	157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00
161.00	CMHC		N	N	N	N	161.00
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	
		Name		County		State	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					Y	
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	
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)					0.50	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet S-2 Part I Date/Time Prepared: 7/30/2015 3:14 pm
		Beginning 1.00	Ending 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)	03/01/2014	02/28/2015	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet S-2 Part II Date/Time Prepared: 7/30/2015 3:14 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
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	Type	Date
			1.00	2.00	3.00
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 Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been 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	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		N		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
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	07/27/2015	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: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet S-2 Part II Date/Time Prepared: 7/30/2015 3:14 pm
---	----------------------	---	--

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	1.00 N	2.00	3.00 N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2013	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
<b>Cost Report Preparer Contact Information</b>					
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.	JEREMY		BURLESON	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 465-3427		JEREMY_BURLESON@CHS.NET	43.00

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
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)	07/27/2015	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	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REVENUE MANAGEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
7/30/2015 3:14 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	58	21,170	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		58	21,170	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	14	5,110	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		72	26,280	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY	45.00	0	0		0	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	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		72				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
7/30/2015 3:14 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,593	407	9,445			1.00
2.00 HMO and other (see instructions)	2,237	1,404				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,593	407	9,445			7.00
8.00 INTENSIVE CARE UNIT	520	77	1,297			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		130	1,264			13.00
14.00 Total (see instructions)	4,113	614	12,006	0.00	476.74	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY		0	0	0.00	0.00	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	0	0	0	0.00	0.00	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	476.74	27.00
28.00 Observation Bed Days		0	2,990			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
7/30/2015 3:14 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,165	372	3,486	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,165	372	3,486	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY	0.00					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	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet S-3 Part II Date/Time Prepared: 7/30/2015 3:14 pm			
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	23,398,807	0	23,398,807	991,629.00	23.60	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		31,075	132,401	163,476	7,379.00	22.15	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor: Direct Patient Care		1,448,600	0	1,448,600	26,354.00	54.97	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		270,253	0	270,253	1,666.00	162.22	13.00
14.00	Home office salaries & wage-related costs		1,519,274	0	1,519,274	28,151.00	53.97	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		5,058,762	0	5,058,762			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		38,022	0	38,022			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	161,902	0	161,902	5,935.00	27.28	26.00
27.00	Administrative & General	5.00	4,672,564	-369,281	4,303,283	178,426.00	24.12	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	512,944	0	512,944	26,055.00	19.69	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	580,332	0	580,332	45,536.00	12.74	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	590,695	-464,230	126,465	9,328.00	13.56	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	464,230	464,230	34,240.00	13.56	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	908,923	236,880	1,145,803	32,294.00	35.48	38.00
39.00	Central Services and Supply	14.00	252,142	0	252,142	15,987.00	15.77	39.00
40.00	Pharmacy	15.00	809,066	0	809,066	21,497.00	37.64	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet S-3  
Part II  
Date/Time Prepared:  
7/30/2015 3:14 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 454,132	0	454,132	27,436.00	16.55	41.00
42.00	Social Service	17.00 0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet S-3  
Part III  
Date/Time Prepared:  
7/30/2015 3:14 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	23,398,807	0	23,398,807	991,629.00	23.60	1.00
2.00	Excluded area salaries (see instructions)	31,075	132,401	163,476	7,379.00	22.15	2.00
3.00	Subtotal salaries (line 1 minus line 2)	23,367,732	-132,401	23,235,331	984,250.00	23.61	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,238,127	0	3,238,127	56,171.00	57.65	4.00
5.00	Subtotal wage-related costs (see inst.)	5,058,762	0	5,058,762	0.00	21.77	5.00
6.00	Total (sum of lines 3 thru 5)	31,664,621	-132,401	31,532,220	1,040,421.00	30.31	6.00
7.00	Total overhead cost (see instructions)	8,942,700	-132,401	8,810,299	396,734.00	22.21	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet S-3 Part IV Date/Time Prepared: 7/30/2015 3:14 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			382,266 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)			2,479,725 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			40,603 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			22,237 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			-267 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			19,677 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			166,105 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only			1,324,886 17.00
18.00	Medicare Taxes - Employers Portion Only			309,852 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			190,969 20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			4,936,053 24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			160,730 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet S-3 Part V Date/Time Prepared: 7/30/2015 3:14 pm
Cost Center Description			Contract Labor	Benefit Cost
PART V - Contract Labor and Benefit Cost			1.00	2.00
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	Subprovider - IPF			0 3.00
4.00	Subprovider - IRF			0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF			0 8.00
9.00	Hospital-Based NF		0	0 9.00
10.00	Hospital-Based OLTC			0 10.00
11.00	Hospital-Based HHA			0 11.00
12.00	Separately Certified ASC			0 12.00
13.00	Hospital-Based Hospice		0	0 13.00
14.00	Hospital-Based Health Clinic RHC			0 14.00
15.00	Hospital-Based Health Clinic FQHC			0 15.00
16.00	Hospital-Based-CMHC			0 16.00
17.00	Renal Dialysis			0 17.00
18.00	Other		0	0 18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet S-10

Date/Time Prepared:  
7/30/2015 3:14 pm

				1.00	
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.127714	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			8,354,528	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			48,034,275	6.00
7.00	Medicaid cost (line 1 times line 6)			6,134,649	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			0	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP			0	9.00
10.00	Stand-alone SCHIP charges			0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			453,253	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			4,583,532	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			585,381	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			132,128	16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			132,128	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,116,922	75,680	1,192,602	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	142,647	9,665	152,312	21.00
22.00	Partial payment by patients approved for charity care	2,952	8,918	11,870	22.00
23.00	Cost of charity care (line 21 minus line 22)	139,695	747	140,442	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			18,900,324	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			-20,967	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			18,921,291	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			2,416,514	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,556,956	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,689,084	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet A  
Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		1,725,196	1,725,196	1,174,889	2,900,085	1.00
2.00	00200		3,554,769	3,554,769	632,497	4,187,266	2.00
4.00	00400				3,211,438	3,480,715	4.00
5.01	00540	161,902	107,375	269,277			
5.02	00560	4,672,564	37,405,797	42,078,361	-29,797,859	12,280,502	5.01
7.00	00700				25,166,594	25,166,594	5.02
8.00	00800	512,944	1,566,762	2,079,706	93,648	2,173,354	7.00
9.00	00900					322,298	8.00
10.00	01000	580,332	245,653	825,985	0	825,985	9.00
11.00	01100	590,695	672,876	1,263,571	-993,431	270,140	10.00
13.00	01300				993,048	993,048	11.00
14.00	01400	908,923	122,676	1,031,599	235,331	1,266,930	13.00
15.00	01500	252,142	3,153,369	3,405,511	-2,825,937	579,574	14.00
16.00	01600	809,066	5,793,063	6,602,129	-5,490,611	1,111,518	15.00
17.00	01700	454,132	414,156	868,288	-1,334	866,954	16.00
		0	20	20	-20	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	3,843,913	2,020,441	5,864,354	-719,654	5,144,700	30.00
31.00	03100	1,124,833	167,508	1,292,341	-2,228	1,290,113	31.00
43.00	04300	0	0	0	223,288	223,288	43.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,270,158	996,794	2,266,952	-1,100	2,265,852	50.00
51.00	05100	638,831	136,602	775,433	-876	774,557	51.00
52.00	05200	0	0	0	487,232	487,232	52.00
53.00	05300	0	924,222	924,222	-18,402	905,820	53.00
54.00	05400	1,978,516	1,668,235	3,646,751	-1,290,031	2,356,720	54.00
54.01	05401	492,497	90,897	583,394	-583,125	269	54.01
54.02	05402	0	127	127	1,502,869	1,502,996	54.02
56.00	05600	143,135	132,824	275,959	0	275,959	56.00
57.00	05700	246,616	312,059	558,675	-45,229	513,446	57.00
58.00	05800	234,749	519,869	754,618	-217,586	537,032	58.00
60.00	06000	1,260,704	2,086,150	3,346,854	-168,230	3,178,624	60.00
65.00	06500	403,417	76,782	480,199	126,093	606,292	65.00
66.00	06600	627,676	1,242,687	1,870,363	-2,648	1,867,715	66.00
67.00	06700	22,283	217,884	240,167	-273	239,894	67.00
68.00	06800	0	23,445	23,445	0	23,445	68.00
69.00	06900	138,919	14,232	153,151	0	153,151	69.00
71.00	07100	0	0	0	490,183	490,183	71.00
72.00	07200	0	0	0	2,320,134	2,320,134	72.00
73.00	07300	0	0	0	5,373,520	5,373,520	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03610	88,204	38,446	126,650	-126,650	0	76.01
76.02	03550	0	0	0	0	0	76.02
76.03	03951	48,712	32,907	81,619	-81,619	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	506,342	25,738	532,080	78,077	610,157	90.00
91.00	09100	1,355,527	522,801	1,878,328	-42,759	1,835,569	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	0	0	0	0	0	116.00
118.00		23,367,732	66,334,660	89,702,392	-300,761	89,401,631	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	31,075	26,211	57,286	-476	56,810	190.00
192.00	19200	0	117,742	117,742	-165,062	-47,320	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	463,983	463,983	194.01
194.02	07952	0	-2,296	-2,296	2,316	20	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
200.00		23,398,807	66,476,317	89,875,124	0	89,875,124	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet A  
Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,435,264	6,335,349	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,138,808	3,048,458	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,571	3,479,144	4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	-375,577	11,904,925	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-22,618,625	2,547,969	5.02
7.00	00700	OPERATION OF PLANT	0	2,173,354	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21	322,319	8.00
9.00	00900	HOUSEKEEPING	0	825,985	9.00
10.00	01000	DIETARY	0	270,140	10.00
11.00	01100	CAFETERIA	-354,040	639,008	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,266,930	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	579,574	14.00
15.00	01500	PHARMACY	0	1,111,518	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33	866,987	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-1,332,483	3,812,217	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,290,113	31.00
43.00	04300	NURSERY	0	223,288	43.00
45.00	04500	NURSING FACILITY	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	2,265,852	50.00
51.00	05100	RECOVERY ROOM	0	774,557	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	487,232	52.00
53.00	05300	ANESTHESIOLOGY	-905,356	464	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-81,963	2,274,757	54.00
54.01	05401	ULTRASOUND	-268	1	54.01
54.02	05402	ONCOLOGY	0	1,502,996	54.02
56.00	05600	RADIOISOTOPE	-330	275,629	56.00
57.00	05700	CT SCAN	-9,104	504,342	57.00
58.00	05800	MRI	-31,740	505,292	58.00
60.00	06000	LABORATORY	-67,618	3,111,006	60.00
65.00	06500	RESPIRATORY THERAPY	0	606,292	65.00
66.00	06600	PHYSICAL THERAPY	0	1,867,715	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	239,894	67.00
68.00	06800	SPEECH PATHOLOGY	0	23,445	68.00
69.00	06900	ELECTROCARDIOLOGY	0	153,151	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	490,183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,320,134	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,373,520	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	610,157	90.00
91.00	09100	EMERGENCY	-128,038	1,707,531	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-23,610,203	65,791,428	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	56,810	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	241,984	194,664	192.00
192.01	19201	WELLNESS CENTER	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	MARKETING	0	463,983	194.01
194.02	07952	SENIOR CIRCLE	-31,496	-31,476	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.05
200.00		TOTAL (SUM OF LINES 118-199)	-23,399,715	66,475,409	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - EMPLOYEE BENEFITS</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,213,200	1.00
2.00		0.00	0	0	2.00
	O		0	3,213,200	
<b>B - OXYGEN</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	43,332	1.00
2.00		0.00	0	0	2.00
	O		0	43,332	
<b>C - LEASE AND RENTAL</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	428,256	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	618,519	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	O		0	1,046,775	
<b>D - OTHER CAPITAL</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	115,356	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	631,277	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,978	3.00
	O		0	760,611	
<b>E - MARKETING</b>					
1.00	MARKETING	194.01	132,401	333,898	1.00
	O		132,401	333,898	
<b>F - CNO COST</b>					
1.00	NURSING ADMINISTRATION	13.00	236,880	0	1.00
	O		236,880	0	
<b>G - CHARGABLE SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	446,851	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,320,134	2.00
3.00	OPERATING ROOM	50.00	0	862	3.00
	O		0	2,767,847	
<b>H - DRUGS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,373,520	1.00
	O		0	5,373,520	
<b>I - LABOR AND DELIVERY</b>					
1.00	NURSERY	43.00	187,950	35,338	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	410,121	77,111	2.00
	O		598,071	112,449	
<b>J - MISC DEPARTMENTS</b>					
1.00	CLINIC	90.00	48,712	32,907	1.00
2.00	RESPIRATORY THERAPY	65.00	88,204	37,889	2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	1,906,536	23,260,058	3.00
4.00	SENIOR CIRCLE	194.02	0	2,316	4.00
5.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	20	5.00
	O		2,043,452	23,333,190	
<b>K - RADIOLOGY</b>					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	492,497	90,628	1.00
2.00	ONCOLOGY	54.02	760,067	742,802	2.00
	O		1,252,564	833,430	

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet A-6  
Date/Time Prepared:  
7/30/2015 3:14 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
L - DIETARY					
1.00	CAFETERIA	11.00	464,230	528,818	1.00
	O		464,230	528,818	
M - MOB UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	95,169	1.00
	O		0	95,169	
500.00	Grand Total: Increases		4,727,598	38,442,239	500.00

RECLASSIFICATIONS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet A-6  
Date/Time Prepared:  
7/30/2015 3:14 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
<b>A - EMPLOYEE BENEFITS</b>						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	3,208,829	0	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4,371	0	2.00
	O		0	3,213,200		
<b>B - OXYGEN</b>						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	24,930	0	1.00
2.00	ANESTHESIOLOGY	53.00	0	18,402	0	2.00
	O		0	43,332		
<b>C - LEASE AND RENTAL</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,762	10	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	24,188	10	2.00
3.00	OPERATION OF PLANT	7.00	0	1,521	0	3.00
4.00	DIETARY	10.00	0	383	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	1,549	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	33,160	0	6.00
7.00	PHARMACY	15.00	0	117,091	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,334	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	9,134	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	2,228	0	10.00
11.00	OPERATING ROOM	50.00	0	1,962	0	11.00
12.00	RECOVERY ROOM	51.00	0	876	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	370,287	0	13.00
14.00	CT SCAN	57.00	0	45,229	0	14.00
15.00	MRI	58.00	0	217,586	0	15.00
16.00	LABORATORY	60.00	0	168,230	0	16.00
17.00	PHYSICAL THERAPY	66.00	0	2,648	0	17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	273	0	18.00
19.00	SLEEP LAB	76.01	0	557	0	19.00
20.00	CLINIC	90.00	0	3,542	0	20.00
21.00	EMERGENCY	91.00	0	42,759	0	21.00
22.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	476	0	22.00
	O		0	1,046,775		
<b>D - OTHER CAPITAL</b>						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	695,089	12	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	65,522	13	2.00
3.00	O	0.00	0	0	12	3.00
	O		0	760,611		
<b>E - MARKETING</b>						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	132,401	333,898	0	1.00
	O		132,401	333,898		
<b>F - CNO COST</b>						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	236,880	0	0	1.00
	O		236,880	0		
<b>G - CHARGABLE SUPPLIES</b>						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,767,847	0	1.00
2.00	O	0.00	0	0	0	2.00
3.00	O	0.00	0	0	0	3.00
	O		0	2,767,847		
<b>H - DRUGS</b>						
1.00	PHARMACY	15.00	0	5,373,520	0	1.00
	O		0	5,373,520		
<b>I - LABOR AND DELIVERY</b>						
1.00	ADULTS & PEDIATRICS	30.00	598,071	112,449	0	1.00
2.00	O	0.00	0	0	0	2.00
	O		598,071	112,449		
<b>J - MISC DEPARTMENTS</b>						
1.00	OTHER ANCILLARY SERVICE COST CENTERS	76.03	48,712	32,907	0	1.00
2.00	SLEEP LAB	76.01	88,204	37,889	0	2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	1,906,536	23,260,058	0	3.00
4.00	MARKETING	194.01	0	2,316	0	4.00
5.00	SOCIAL SERVICE	17.00	0	20	0	5.00
	O		2,043,452	23,333,190		
<b>K - RADIOLOGY</b>						
1.00	ULTRASOUND	54.01	492,497	90,628	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	760,067	742,802	0	2.00
	O		1,252,564	833,430		

RECLASSIFICATIONS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet A-6

Date/Time Prepared:  
7/30/2015 3:14 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
L - DIETARY						
1.00	DIETARY	10.00	464,230	528,818	0	1.00
	O		464,230	528,818		
M - MOB UTILITIES						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	95,169	0	1.00
	O		0	95,169		
500.00	Grand Total: Decreases		4,727,598	38,442,239		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet A-7  
Part I  
Date/Time Prepared:  
7/30/2015 3:14 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	2,381,252	0	0	0	1.00
2.00	Land Improvements	1,881,289	63,463	0	63,463	2.00
3.00	Buildings and Fixtures	55,329,567	908,935	0	908,935	3.00
4.00	Building Improvements	44,845	0	0	0	4.00
5.00	Fixed Equipment	4,945,942	470,321	0	470,321	5.00
6.00	Movable Equipment	37,908,911	1,031,249	0	1,031,249	6.00
7.00	HIT designated Assets	2,375,096	89,387	0	89,387	7.00
8.00	Subtotal (sum of lines 1-7)	104,866,902	2,563,355	0	2,563,355	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	104,866,902	2,563,355	0	2,563,355	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	2,381,252	0			1.00
2.00	Land Improvements	1,944,752	0			2.00
3.00	Buildings and Fixtures	56,238,502	0			3.00
4.00	Building Improvements	44,845	0			4.00
5.00	Fixed Equipment	5,410,751	0			5.00
6.00	Movable Equipment	38,669,726	0			6.00
7.00	HIT designated Assets	2,464,483	0			7.00
8.00	Subtotal (sum of lines 1-7)	107,154,311	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	107,154,311	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet A-7  
Part II  
Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,725,196	1,725,196				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,554,769	3,554,769				2.00
3.00	Total (sum of lines 1-2)	5,279,965	5,279,965				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet A-7  
Part III  
Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,170,841	349,377	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	-1,257,500	618,519	2.00
3.00	Total (sum of lines 1-2)	0	0	0	-86,659	967,896	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	2,298,916	115,356	631,277	1,769,582	6,335,349	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,978	0	3,673,461	3,048,458	2.00
3.00	Total (sum of lines 1-2)	2,298,916	129,334	631,277	5,443,043	9,383,807	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet A-8

Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst.	A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	B	-816		OTHER ADMINISTRATIVE AND GENERAL	5.01		0	7.00
8.00 Television and radio service (chapter 21)	A	-24,159		CAP REL COSTS-MVBLE EQUIP	2.00		9	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,456,952					0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-14		RADIOLOGY-DIAGNOSTIC	54.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,810,067					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-354,040		CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients			0		0.00		0	17.00
18.00 Sale of medical records and abstracts	B	33		MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines			0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3			RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	1,170,841		CAP REL COSTS-BLDG & FIXT	1.00		9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,222,447		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			OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)				ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 PENALTIES	A	-1,512		OTHER ADMINISTRATIVE AND GENERAL	5.01		0	33.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
34.00 RENTAL INCOME	B	-78,879	CAP REL COSTS-BLDG & FIXT	1.00	10 34.00
35.00 MISC INCOME	B	-52,252	OTHER ADMINSTRATIVE AND GENERAL	5.01	0 35.00
36.00 HOSPITAL BAD DEBT	A	-21,102,106	OTHER ADMINSTRATIVE AND GENERAL	5.02	0 36.00
37.00 PATIENT PHONE WAGE COST	A	-7,212	OTHER ADMINSTRATIVE AND GENERAL	5.02	0 37.00
38.00 PATIENT PHONE BENEFIT COSTS	A	-1,571	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 38.00
39.00 PATIENT PHONE EXPENSE	A	-17,269	OTHER ADMINSTRATIVE AND GENERAL	5.02	0 39.00
40.00 PATIENT PHONE DEPRECIATION	A	-1,230	CAP REL COSTS-MVBLE EQUIP	2.00	9 40.00
41.00 PATIENT TV - DEPRECIATION	A	-9,664	CAP REL COSTS-MVBLE EQUIP	2.00	9 41.00
42.00 MARKETING	A	-223,486	OTHER ADMINSTRATIVE AND GENERAL	5.01	0 42.00
43.00 PHYSICIAN RECRUITING	A	-8,991	OTHER ADMINSTRATIVE AND GENERAL	5.01	0 43.00
44.00 CHARITABLE CONTRIBUTIONS	A	-7,976	OTHER ADMINSTRATIVE AND GENERAL	5.01	0 44.00
45.00 UNCOLLECTED PHYSICIAN RENT	A	-11,074	OTHER ADMINSTRATIVE AND GENERAL	5.01	0 45.00
45.01 MINORITY INTEREST	A	-446,466	OTHER ADMINSTRATIVE AND GENERAL	5.01	0 45.01
45.02 LOBBYING EXPENSE IN ASSOCIATION DUES	A	-3,041	OTHER ADMINSTRATIVE AND GENERAL	5.01	0 45.02
45.03 TRANSPORTATION COSTS	A	-428	OTHER ADMINSTRATIVE AND GENERAL	5.01	0 45.03
45.04 LEGAL FEES	A	-14,561	OTHER ADMINSTRATIVE AND GENERAL	5.01	0 45.04
45.05 POB DEPRECIATION	A	-181,062	PHYSICIANS' PRIVATE OFFICES	192.00	0 45.05
45.06 POB RENT	A	423,046	PHYSICIANS' PRIVATE OFFICES	192.00	0 45.06
45.07 SPECIAL EVENTS	A	-4,622	OTHER ADMINSTRATIVE AND GENERAL	5.01	0 45.07
45.08 NON-ALLOWABLE LEGAL EXPENSE (DOJ)	A	-553,065	OTHER ADMINSTRATIVE AND GENERAL	5.01	0 45.08
45.09 MEALS AND ENTERTAINMENT	A	-18,807	OTHER ADMINSTRATIVE AND GENERAL	5.01	0 45.09
45.10		0		0.00	0 45.10
45.11		0		0.00	0 45.11
45.12 OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0 45.12
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-23,399,715			50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 150133

Period: From 03/01/2014 To 02/28/2015

Worksheet A-8-1

Date/Time Prepared: 7/30/2015 3:14 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	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	Direct Allocation - Capital -	2,298,916	0
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	26,712	0
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	3,902	0
4.00	5.01	OTHER ADMINISTRATIVE AND GEN	PASI Operating Costs	418,065	0
4.01	1.00	CAP REL COSTS-BLDG & FIXT	Pre-Acq Legacy Capital Costs	3,464	0
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	Pre-Acq Legacy Capital Costs	20,452	0
4.03	5.01	OTHER ADMINISTRATIVE AND GEN	Pre- Acq Period Non-Capital	212,499	0
4.04	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	14,210	0
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm	94,338	0
4.06	5.01	OTHER ADMINISTRATIVE AND GEN	Non-Capital Home Office Cost	1,361,023	0
4.07	5.01	OTHER ADMINISTRATIVE AND GEN	Malpractice Costs (See Exhib	345,245	0
4.08	5.02	OTHER ADMINISTRATIVE AND GEN	CIG Leased Equipment (See Ex	112,250	0
4.09	5.02	OTHER ADMINISTRATIVE AND GEN	Management Fees	0	793,193
4.10	5.01	OTHER ADMINISTRATIVE AND GEN	401K Fees	0	3,759
4.11	5.01	OTHER ADMINISTRATIVE AND GEN	Audit Fees	0	69,091
4.12	5.01	OTHER ADMINISTRATIVE AND GEN	Corporate Overhead Allocatio	0	239,366
4.13	5.01	OTHER ADMINISTRATIVE AND GEN	MIS Fees	0	429,988
4.14	5.01	OTHER ADMINISTRATIVE AND GEN	Managed Care	0	58,836
4.15	5.01	OTHER ADMINISTRATIVE AND GEN	Case Management	0	188,962
4.16	5.01	OTHER ADMINISTRATIVE AND GEN	Purchase & Ancillary	0	10,867
4.17	91.00	EMERGENCY	Emergency Room	0	113,038
4.18	5.01	OTHER ADMINISTRATIVE AND GEN	PPSI Fees	0	24,420
4.19	5.01	OTHER ADMINISTRATIVE AND GEN	Compliance/HIM/CCA Fees	0	50,297
4.20	194.02	SENIOR CIRCLE	Senior Circle	0	31,496
4.21	5.02	OTHER ADMINISTRATIVE AND GEN	PASI Collection Fees	0	515,297
4.22	5.02	OTHER ADMINISTRATIVE AND GEN	EBOS Fees	0	10,617
4.23	5.02	OTHER ADMINISTRATIVE AND GEN	PASI Lien Unit Collection Fe	0	111,198
4.24	5.01	OTHER ADMINISTRATIVE AND GEN	Malpractice Allocations (Per	0	276,622
4.25	5.02	OTHER ADMINISTRATIVE AND GEN	CIG Leased Equipment (Per Ex	0	173,983
4.26	8.00	LAUNDRY & LINEN SERVICE	Laundry Revenue	313,918	0
4.27	8.00	LAUNDRY & LINEN SERVICE	Laundry (per GL)	0	313,897
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,224,994	3,414,927

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

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

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

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

6.00	B		0.00	COMMUNITY HEALTH SYSTEMS	100.00	6.00
7.00	C		0.00	HOSPITAL LAUNDR	20.00	7.00
8.00	G		0.00	PASI	0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet A-8-1

Date/Time Prepared:  
7/30/2015 3:14 pm

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

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

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

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

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet A-8-1

Date/Time Prepared:  
7/30/2015 3:14 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	2,298,916	11		1.00
2.00	26,712	14		2.00
3.00	3,902	14		3.00
4.00	418,065	0		4.00
4.01	3,464	14		4.01
4.02	20,452	14		4.02
4.03	212,499	0		4.03
4.04	14,210	14		4.04
4.05	94,338	14		4.05
4.06	1,361,023	0		4.06
4.07	345,245	0		4.07
4.08	112,250	0		4.08
4.09	-793,193	0		4.09
4.10	-3,759	0		4.10
4.11	-69,091	0		4.11
4.12	-239,366	0		4.12
4.13	-429,988	0		4.13
4.14	-58,836	0		4.14
4.15	-188,962	0		4.15
4.16	-10,867	0		4.16
4.17	-113,038	0		4.17
4.18	-24,420	0		4.18
4.19	-50,297	0		4.19
4.20	-31,496	0		4.20
4.21	-515,297	0		4.21
4.22	-10,617	0		4.22
4.23	-111,198	0		4.23
4.24	-276,622	0		4.24
4.25	-173,983	0		4.25
4.26	313,918	0		4.26
4.27	-313,897	0		4.27
5.00	1,810,067			5.00

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

Related Organization(s) and/or Home Office	Type of Business	
		6.00

**B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:**

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet A-8-2

Date/Time Prepared:  
7/30/2015 3:14 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	13,104	13,104	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,332,483	1,332,483	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	905,356	905,356	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	81,949	81,949	0	0	0	5.00
6.00	54.01	ULTRASOUND	268	268	0	0	0	6.00
7.00	56.00	RADIOISOTOPE	330	330	0	0	0	7.00
8.00	57.00	CT SCAN	9,104	9,104	0	0	0	8.00
9.00	58.00	MRI	31,740	31,740	0	0	0	9.00
10.00	60.00	LABORATORY	67,618	67,618	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	15,000	15,000	0	0	0	12.00
200.00			2,456,952	2,456,952	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	54.01	ULTRASOUND	0	0	0	0	0	6.00
7.00	56.00	RADIOISOTOPE	0	0	0	0	0	7.00
8.00	57.00	CT SCAN	0	0	0	0	0	8.00
9.00	58.00	MRI	0	0	0	0	0	9.00
10.00	60.00	LABORATORY	0	0	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	13,104	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,332,483	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	905,356	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	81,949	5.00
6.00	54.01	ULTRASOUND	0	0	0	268	6.00
7.00	56.00	RADIOISOTOPE	0	0	0	330	7.00
8.00	57.00	CT SCAN	0	0	0	9,104	8.00
9.00	58.00	MRI	0	0	0	31,740	9.00
10.00	60.00	LABORATORY	0	0	0	67,618	10.00
11.00	90.00	CLINIC	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	15,000	12.00
200.00			0	0	0	2,456,952	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet B  
Part I  
Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	6,335,349	6,335,349			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	3,048,458		3,048,458		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,479,144	16,476	7,928	3,503,548	4.00
5.01 00540	OTHER ADMINISTRATIVE AND GENERAL	11,904,925	307,914	148,163	361,370	12,722,372 5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	2,547,969	494,584	237,985	287,458	3,567,996 5.02
7.00 00700	OPERATION OF PLANT	2,173,354	504,534	242,773	77,339	2,998,000 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	322,319	10,223	4,919	0	337,461 8.00
9.00 00900	HOUSEKEEPING	825,985	21,570	10,379	87,500	945,434 9.00
10.00 01000	DIETARY	270,140	59,259	28,514	19,068	376,981 10.00
11.00 01100	CAFETERIA	639,008	49,785	23,956	69,994	782,743 11.00
13.00 01300	NURSING ADMINISTRATION	1,266,930	12,898	6,206	172,758	1,458,792 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	579,574	34,247	16,479	38,017	668,317 14.00
15.00 01500	PHARMACY	1,111,518	42,766	20,578	121,987	1,296,849 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	866,987	47,196	22,710	68,472	1,005,365 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	3,812,217	716,591	344,811	489,393	5,363,012 30.00
31.00 03100	INTENSIVE CARE UNIT	1,290,113	160,176	77,074	169,597	1,696,960 31.00
43.00 04300	NURSERY	223,288	15,334	7,379	28,338	274,339 43.00
45.00 04500	NURSING FACILITY	0	0	0	0	0 45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	2,265,852	298,253	143,514	191,508	2,899,127 50.00
51.00 05100	RECOVERY ROOM	774,557	14,056	6,764	96,320	891,697 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	487,232	58,645	28,219	61,836	635,932 52.00
53.00 05300	ANESTHESIOLOGY	464	0	0	0	464 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,274,757	222,143	106,892	257,968	2,861,760 54.00
54.01 05401	ULTRASOUND	1	0	0	0	1 54.01
54.02 05402	ONCOLOGY	1,502,996	201,084	96,758	114,599	1,915,437 54.02
56.00 05600	RADIOISOTOPE	275,629	8,706	4,189	21,581	310,105 56.00
57.00 05700	CT SCAN	504,342	33,003	15,880	37,184	590,409 57.00
58.00 05800	MRI	505,292	59,923	28,834	35,394	629,443 58.00
60.00 06000	LABORATORY	3,111,006	103,848	49,970	190,083	3,454,907 60.00
65.00 06500	RESPIRATORY THERAPY	606,292	51,506	24,784	74,124	756,706 65.00
66.00 06600	PHYSICAL THERAPY	1,867,715	150,481	72,409	94,638	2,185,243 66.00
67.00 06700	OCCUPATIONAL THERAPY	239,894	0	0	3,360	243,254 67.00
68.00 06800	SPEECH PATHOLOGY	23,445	1,704	820	0	25,969 68.00
69.00 06900	ELECTROCARDIOLOGY	153,151	852	410	20,946	175,359 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	490,183	0	0	0	490,183 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	2,320,134	0	0	0	2,320,134 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	5,373,520	0	0	0	5,373,520 73.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.00
76.01 03610	SLEEP LAB	0	0	0	0	0 76.01
76.02 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0 76.02
76.03 03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	610,157	64,881	31,220	83,688	789,946 90.00
91.00 09100	EMERGENCY	1,707,531	228,311	109,859	204,380	2,250,081 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00 11600	HOSPICE	0	0	0	0	0 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	65,791,428	3,990,949	1,920,376	3,478,900	62,294,298 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	56,810	10,478	5,042	4,685	77,015 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	194,664	2,097,364	1,009,213	0	3,301,241 192.00
192.01 19201	WELLNESS CENTER	0	200,931	96,684	0	297,615 192.01
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
194.01 07951	MARKETING	463,983	35,627	17,143	19,963	536,716 194.01
194.02 07952	SENIOR CIRCLE	-31,476	0	0	0	-31,476 194.02
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.03
194.04 07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.04
194.05 07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.05
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)	66,475,409	6,335,349	3,048,458	3,503,548	66,475,409 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet B  
Part I  
Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL 5.01	Subtotal 5A.01	OTHER ADMINISTRATIVE AND GENERAL 5.02	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	12,722,372					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	843,984	4,411,980	4,411,980			5.02
7.00	00700	OPERATION OF PLANT	709,156	3,707,156	281,937	3,989,093		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,824	417,285	31,735	8,137	457,157	8.00
9.00	00900	HOUSEKEEPING	223,636	1,169,070	88,910	17,169	0	9.00
10.00	01000	DIETARY	89,172	466,153	35,452	47,166	0	10.00
11.00	01100	CAFETERIA	185,152	967,895	73,610	39,626	0	11.00
13.00	01300	NURSING ADMINISTRATION	345,067	1,803,859	137,187	10,266	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	158,086	826,403	62,850	27,258	15,964	14.00
15.00	01500	PHARMACY	306,761	1,603,610	121,958	34,039	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	237,812	1,243,177	94,546	37,565	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	1,268,583	6,631,595	504,346	570,359	151,658	30.00
31.00	03100	INTENSIVE CARE UNIT	401,404	2,098,364	159,585	127,489	27,938	31.00
43.00	04300	NURSERY	64,893	339,232	25,799	12,205	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	685,768	3,584,895	272,638	237,390	101,771	50.00
51.00	05100	RECOVERY ROOM	210,925	1,102,622	83,857	11,188	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	150,425	786,357	59,804	46,678	0	52.00
53.00	05300	ANESTHESIOLOGY	110	574	44	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	676,929	3,538,689	269,124	176,811	0	54.00
54.01	05401	ULTRASOUND	0	1	0	0	0	54.01
54.02	05402	ONCOLOGY	453,083	2,368,520	180,131	160,050	5,186	54.02
56.00	05600	RADIOLOGY	73,353	383,458	29,163	6,930	42,111	56.00
57.00	05700	CT SCAN	139,657	730,066	55,523	26,268	0	57.00
58.00	05800	MRI	148,890	778,333	59,194	47,695	0	58.00
60.00	06000	LABORATORY	817,234	4,272,141	324,905	82,656	0	60.00
65.00	06500	RESPIRATORY THERAPY	178,994	935,700	71,162	40,996	0	65.00
66.00	06600	PHYSICAL THERAPY	516,904	2,702,147	205,504	119,773	27,239	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,540	300,794	22,876	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,143	32,112	2,442	1,356	0	68.00
69.00	06900	ELECTROCARDIOLOGY	41,480	216,839	16,491	678	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	115,949	606,132	46,098	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	548,811	2,868,945	218,189	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,271,093	6,644,613	505,326	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	186,856	976,802	74,288	51,641	7,982	90.00
91.00	09100	EMERGENCY	532,241	2,782,322	211,601	181,721	55,874	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,725,915	61,297,841	4,326,275	2,123,110	435,723	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,217	95,232	7,243	8,340	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	780,885	4,082,126	0	1,669,358	0	192.00
192.01	19201	WELLNESS CENTER	70,399	368,014	27,988	159,928	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	9,446	194.00
194.01	07951	MARKETING	126,956	663,672	50,474	28,357	0	194.01
194.02	07952	SENIOR CIRCLE	0	-31,476	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	11,988	194.05
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,722,372	66,475,409	4,411,980	3,989,093	457,157	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet B  
Part I  
Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY		
		9.00	10.00	11.00	13.00	14.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL					5.01	
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL					5.02	
7.00	00700	OPERATION OF PLANT					7.00	
8.00	00800	LAUNDRY & LINEN SERVICE					8.00	
9.00	00900	HOUSEKEEPING	1,275,149				9.00	
10.00	01000	DIETARY	26,228	574,999			10.00	
11.00	01100	CAFETERIA	22,036	0	1,103,167		11.00	
13.00	01300	NURSING ADMINISTRATION	5,709	0	51,485	2,008,506	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	15,158	0	25,494	43,315	1,016,442	14.00
15.00	01500	PHARMACY	18,929	0	34,279	0	17,456	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,889	0	43,728	0	1,278	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	317,168	310,000	218,637	557,596	60,031	30.00
31.00	03100	INTENSIVE CARE UNIT	70,895	46,113	63,950	193,233	15,535	31.00
43.00	04300	NURSERY	6,787	0	9,249	32,288	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	132,009	14,245	68,824	218,198	155,448	50.00
51.00	05100	RECOVERY ROOM	6,222	0	34,346	109,743	9,995	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,957	55,395	20,190	70,454	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	89	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,323	0	109,534	0	20,125	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	89,002	0	41,506	130,570	8,757	54.02
56.00	05600	RADIOISOTOPE	3,854	0	6,862	0	272	56.00
57.00	05700	CT SCAN	14,607	0	15,449	0	14,318	57.00
58.00	05800	MRI	26,523	0	13,427	0	685	58.00
60.00	06000	LABORATORY	45,964	0	107,645	216,574	90,728	60.00
65.00	06500	RESPIRATORY THERAPY	22,797	0	32,688	84,455	5,784	65.00
66.00	06600	PHYSICAL THERAPY	66,604	0	55,563	0	4,549	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,718	0	857	67.00
68.00	06800	SPEECH PATHOLOGY	754	0	0	0	2	68.00
69.00	06900	ELECTROCARDIOLOGY	377	0	11,736	23,865	513	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	85,676	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	444,843	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	27,963	0	40,412	95,352	21,447	90.00
91.00	09100	EMERGENCY	101,053	0	83,676	232,863	50,651	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,165,808	425,753	1,091,398	2,008,506	1,009,039	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,638	0	3,216	0	4,818	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	558	192.00
192.01	19201	WELLNESS CENTER	88,934	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	15,769	0	8,553	0	2,027	194.01
194.02	07952	SENIOR CIRCLE	0	52,196	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	97,050	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,275,149	574,999	1,103,167	2,008,506	1,016,442	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet B  
Part I  
Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,830,271					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,441,183				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	126,786	0	9,448,176	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,603	0	2,811,705	0	31.00
43.00	04300	NURSERY	0	4,301	0	429,861	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	160,731	0	4,946,149	0	50.00
51.00	05100	RECOVERY ROOM	0	15,323	0	1,373,296	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,386	0	1,074,221	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	707	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,887	0	4,264,493	0	54.00
54.01	05401	ULTRASOUND	0	0	0	1	0	54.01
54.02	05402	ONCOLOGY	0	43,611	0	3,027,333	0	54.02
56.00	05600	RADIOISOTOPE	0	18,189	0	490,839	0	56.00
57.00	05700	CT SCAN	0	155,684	0	1,011,915	0	57.00
58.00	05800	MRI	0	39,739	0	965,596	0	58.00
60.00	06000	LABORATORY	0	158,823	0	5,299,436	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	28,825	0	1,222,407	0	65.00
66.00	06600	PHYSICAL THERAPY	0	21,413	0	3,202,792	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,210	0	331,455	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	488	0	37,154	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,058	0	279,557	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	41,935	0	779,841	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	45,573	0	3,577,550	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,830,271	382,855	0	9,363,065	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	15,410	0	1,311,297	0	90.00
91.00	09100	EMERGENCY	0	98,353	0	3,798,114	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,830,271	1,441,183	0	59,046,960	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	123,487	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	5,752,042	0	192.00
192.01	19201	WELLNESS CENTER	0	0	0	644,864	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	9,446	0	194.00
194.01	07951	MARKETING	0	0	0	768,852	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	20,720	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	97,050	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	11,988	0	194.05
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,830,271	1,441,183	0	66,475,409	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet B  
Part I  
Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	5.02
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
45.00	04500	NURSING FACILITY	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
54.02	05402	ONCOLOGY	54.02
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	76.00
76.01	03610	SLEEP LAB	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02
76.03	03951	OTHER ANCILLARY SERVICE COST CENTERS	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00	09500	AMBULANCE SERVICES	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	WELLNESS CENTER	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	MARKETING	194.01
194.02	07952	SENIOR CIRCLE	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	194.05
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet B  
Part II  
Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	16,476	7,928	24,404	24,404 4.00
5.01 00540	OTHER ADMINISTRATIVE AND GENERAL	0	307,914	148,163	456,077	2,517 5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	0	494,584	237,985	732,569	2,002 5.02
7.00 00700	OPERATION OF PLANT	0	504,534	242,773	747,307	539 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	10,223	4,919	15,142	0 8.00
9.00 00900	HOUSEKEEPING	0	21,570	10,379	31,949	609 9.00
10.00 01000	DIETARY	0	59,259	28,514	87,773	133 10.00
11.00 01100	CAFETERIA	0	49,785	23,956	73,741	487 11.00
13.00 01300	NURSING ADMINISTRATION	0	12,898	6,206	19,104	1,203 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	34,247	16,479	50,726	265 14.00
15.00 01500	PHARMACY	0	42,766	20,578	63,344	850 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	47,196	22,710	69,906	477 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	716,591	344,811	1,061,402	3,413 30.00
31.00 03100	INTENSIVE CARE UNIT	0	160,176	77,074	237,250	1,181 31.00
43.00 04300	NURSERY	0	15,334	7,379	22,713	197 43.00
45.00 04500	NURSING FACILITY	0	0	0	0	0 45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	298,253	143,514	441,767	1,334 50.00
51.00 05100	RECOVERY ROOM	0	14,056	6,764	20,820	671 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	58,645	28,219	86,864	431 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	222,143	106,892	329,035	1,796 54.00
54.01 05401	ULTRASOUND	0	0	0	0	0 54.01
54.02 05402	ONCOLOGY	0	201,084	96,758	297,842	798 54.02
56.00 05600	RADIO SOTOPE	0	8,706	4,189	12,895	150 56.00
57.00 05700	CT SCAN	0	33,003	15,880	48,883	259 57.00
58.00 05800	MRI	0	59,923	28,834	88,757	246 58.00
60.00 06000	LABORATORY	0	103,848	49,970	153,818	1,324 60.00
65.00 06500	RESPIRATORY THERAPY	0	51,506	24,784	76,290	516 65.00
66.00 06600	PHYSICAL THERAPY	0	150,481	72,409	222,890	659 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	23 67.00
68.00 06800	SPEECH PATHOLOGY	0	1,704	820	2,524	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	852	410	1,262	146 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.00
76.01 03610	SLEEP LAB	0	0	0	0	0 76.01
76.02 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0 76.02
76.03 03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	64,881	31,220	96,101	583 90.00
91.00 09100	EMERGENCY	0	228,311	109,859	338,170	1,423 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00 11600	HOSPICE	0	0	0	0	0 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,990,949	1,920,376	5,911,325	24,232 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,478	5,042	15,520	33 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	2,097,364	1,009,213	3,106,577	0 192.00
192.01 19201	WELLNESS CENTER	0	200,931	96,684	297,615	0 192.01
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
194.01 07951	MARKETING	0	35,627	17,143	52,770	139 194.01
194.02 07952	SENIOR CIRCLE	0	0	0	0	0 194.02
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.03
194.04 07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.04
194.05 07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.05
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	6,335,349	3,048,458	9,383,807	24,404 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet B  
Part II  
Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL 5.01	OTHER ADMINISTRATIVE AND GENERAL 5.02	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540	458,594					5.01
5.02	00560	30,424	764,995				5.02
7.00	00700	25,564	48,886	822,296			7.00
8.00	00800	2,878	5,503	1,677	25,200		8.00
9.00	00900	8,062	15,417	3,539	0	59,576	9.00
10.00	01000	3,215	6,147	9,723	0	1,225	10.00
11.00	01100	6,674	12,764	8,168	0	1,030	11.00
13.00	01300	12,439	23,787	2,116	0	267	13.00
14.00	01400	5,699	10,898	5,619	880	708	14.00
15.00	01500	11,058	21,147	7,017	0	884	15.00
16.00	01600	8,573	16,394	7,743	0	976	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	45,730	87,451	117,571	8,360	14,819	30.00
31.00	03100	14,470	27,671	26,280	1,540	3,312	31.00
43.00	04300	2,339	4,473	2,516	0	317	43.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	24,721	47,274	48,935	5,610	6,168	50.00
51.00	05100	7,604	14,540	2,306	0	291	51.00
52.00	05200	5,423	10,370	9,622	0	1,213	52.00
53.00	05300	4	8	0	0	0	53.00
54.00	05400	24,402	46,665	36,447	0	4,594	54.00
54.01	05401	0	0	0	0	0	54.01
54.02	05402	16,333	31,234	32,992	286	4,158	54.02
56.00	05600	2,644	5,057	1,428	2,321	180	56.00
57.00	05700	5,034	9,627	5,415	0	682	57.00
58.00	05800	5,367	10,264	9,832	0	1,239	58.00
60.00	06000	29,460	56,337	17,038	0	2,147	60.00
65.00	06500	6,452	12,339	8,451	0	1,065	65.00
66.00	06600	18,634	35,633	24,690	1,501	3,112	66.00
67.00	06700	2,074	3,967	0	0	0	67.00
68.00	06800	221	423	280	0	35	68.00
69.00	06900	1,495	2,859	140	0	18	69.00
71.00	07100	4,180	7,993	0	0	0	71.00
72.00	07200	19,784	37,833	0	0	0	72.00
73.00	07300	45,793	87,602	0	0	0	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03610	0	0	0	0	0	76.01
76.02	03550	0	0	0	0	0	76.02
76.03	03951	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	6,736	12,881	10,645	440	1,306	90.00
91.00	09100	19,186	36,690	37,459	3,080	4,721	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	0	0	0	0	0	116.00
118.00		422,672	750,134	437,649	24,018	54,467	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	657	1,256	1,719	0	217	190.00
192.00	19200	28,150	0	344,116	0	0	192.00
192.01	19201	2,538	4,853	32,967	0	4,155	192.01
194.00	07950	0	0	0	521	0	194.00
194.01	07951	4,577	8,752	5,845	0	737	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	661	0	194.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		458,594	764,995	822,296	25,200	59,576	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet B  
Part II  
Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	108,216					10.00
11.00	01100		102,864				11.00
13.00	01300		4,801	63,717			13.00
14.00	01400		2,377	1,374	78,546		14.00
15.00	01500		3,196	0	1,349	108,845	15.00
16.00	01600		4,077	0	99	0	16.00
17.00	01700		0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	58,343	20,388	17,688	4,639	0	30.00
31.00	03100	8,679	5,963	6,130	1,200	0	31.00
43.00	04300	0	862	1,024	0	0	43.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	2,681	6,417	6,922	12,012	0	50.00
51.00	05100	0	3,203	3,482	772	0	51.00
52.00	05200	10,425	1,883	2,235	0	0	52.00
53.00	05300	0	0	0	7	0	53.00
54.00	05400	0	10,213	0	1,555	0	54.00
54.01	05401	0	0	0	0	0	54.01
54.02	05402	0	3,870	4,142	677	0	54.02
56.00	05600	0	640	0	21	0	56.00
57.00	05700	0	1,441	0	1,106	0	57.00
58.00	05800	0	1,252	0	53	0	58.00
60.00	06000	0	10,037	6,871	7,011	0	60.00
65.00	06500	0	3,048	2,679	447	0	65.00
66.00	06600	0	5,181	0	351	0	66.00
67.00	06700	0	253	0	66	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	1,094	757	40	0	69.00
71.00	07100	0	0	0	6,621	0	71.00
72.00	07200	0	0	0	34,377	0	72.00
73.00	07300	0	0	0	0	108,845	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03610	0	0	0	0	0	76.01
76.02	03550	0	0	0	0	0	76.02
76.03	03951	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	3,768	3,025	1,657	0	90.00
91.00	09100	0	7,802	7,388	3,914	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	0	0	0	0	0	116.00
118.00		80,128	101,766	63,717	77,974	108,845	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	300	0	372	0	190.00
192.00	19200	0	0	0	43	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	798	0	157	0	194.01
194.02	07952	9,823	0	0	0	0	194.02
194.03	07953	18,265	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		108,216	102,864	63,717	78,546	108,845	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet B  
Part II  
Date/Time Prepared:  
7/30/2015 3:14 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL					5.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	108,245				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	9,518	0	1,449,322	0	1,449,322
31.00	03100	INTENSIVE CARE UNIT	646	0	334,322	0	334,322
43.00	04300	NURSERY	323	0	34,764	0	34,764
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	12,066	0	615,907	0	615,907
51.00	05100	RECOVERY ROOM	1,150	0	54,839	0	54,839
52.00	05200	DELIVERY ROOM & LABOR ROOM	705	0	129,171	0	129,171
53.00	05300	ANESTHESIOLOGY	0	0	19	0	19
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,895	0	458,602	0	458,602
54.01	05401	ULTRASOUND	0	0	0	0	54.01
54.02	05402	ONCOLOGY	3,274	0	395,606	0	395,606
56.00	05600	RADIOISOTOPE	1,366	0	26,702	0	26,702
57.00	05700	CT SCAN	11,688	0	84,135	0	84,135
58.00	05800	MRI	2,983	0	119,993	0	119,993
60.00	06000	LABORATORY	11,923	0	295,966	0	295,966
65.00	06500	RESPIRATORY THERAPY	2,164	0	113,451	0	113,451
66.00	06600	PHYSICAL THERAPY	1,608	0	314,259	0	314,259
67.00	06700	OCCUPATIONAL THERAPY	316	0	6,699	0	6,699
68.00	06800	SPEECH PATHOLOGY	37	0	3,520	0	3,520
69.00	06900	ELECTROCARDIOLOGY	680	0	8,491	0	8,491
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,148	0	21,942	0	21,942
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,421	0	95,415	0	95,415
73.00	07300	DRUGS CHARGED TO PATIENTS	28,793	0	271,033	0	271,033
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	1,157	0	138,299	0	138,299
91.00	09100	EMERGENCY	7,384	0	467,217	0	467,217
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	108,245	0	5,439,674	0	5,439,674
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	20,074	0	20,074
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,478,886	0	3,478,886
192.01	19201	WELLNESS CENTER	0	0	342,128	0	342,128
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	521	0	521
194.01	07951	MARKETING	0	0	73,775	0	73,775
194.02	07952	SENIOR CIRCLE	0	0	9,823	0	9,823
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	18,265	0	18,265
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	661	0	661
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	108,245	0	9,383,807	0	9,383,807

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet B-1

Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	371,833				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		371,833			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	967	967	23,236,905		4.00
5.01 00540	OTHER ADMINISTRATIVE AND GENERAL	18,072	18,072	2,396,747	-12,722,372	5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	29,028	29,028	1,906,536	0	5.02
7.00 00700	OPERATION OF PLANT	29,612	29,612	512,944	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	600	600	0	0	8.00
9.00 00900	HOUSEKEEPING	1,266	1,266	580,332	0	9.00
10.00 01000	DIETARY	3,478	3,478	126,465	0	10.00
11.00 01100	CAFETERIA	2,922	2,922	464,230	0	11.00
13.00 01300	NURSING ADMINISTRATION	757	757	1,145,803	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,010	2,010	252,142	0	14.00
15.00 01500	PHARMACY	2,510	2,510	809,066	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,770	2,770	454,132	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	42,058	42,058	3,245,842	0	30.00
31.00 03100	INTENSIVE CARE UNIT	9,401	9,401	1,124,833	0	31.00
43.00 04300	NURSERY	900	900	187,950	0	43.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	17,505	17,505	1,270,158	0	50.00
51.00 05100	RECOVERY ROOM	825	825	638,831	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,442	3,442	410,121	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	13,038	13,038	1,710,946	0	54.00
54.01 05401	ULTRASOUND	0	0	0	0	54.01
54.02 05402	ONCOLOGY	11,802	11,802	760,067	0	54.02
56.00 05600	RADIOISOTOPE	511	511	143,135	0	56.00
57.00 05700	CT SCAN	1,937	1,937	246,616	0	57.00
58.00 05800	MRI	3,517	3,517	234,749	0	58.00
60.00 06000	LABORATORY	6,095	6,095	1,260,704	0	60.00
65.00 06500	RESPIRATORY THERAPY	3,023	3,023	491,621	0	65.00
66.00 06600	PHYSICAL THERAPY	8,832	8,832	627,676	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	22,283	0	67.00
68.00 06800	SPEECH PATHOLOGY	100	100	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	50	50	138,919	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
76.01 03610	SLEEP LAB	0	0	0	0	76.01
76.02 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.02
76.03 03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	3,808	3,808	555,054	0	90.00
91.00 09100	EMERGENCY	13,400	13,400	1,355,527	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	234,236	234,236	23,073,429	-12,722,372	49,571,926
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	615	615	31,075	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	123,098	123,098	0	0	192.00
192.01 19201	WELLNESS CENTER	11,793	11,793	0	0	192.01
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	MARKETING	2,091	2,091	132,401	0	194.01
194.02 07952	SENIOR CIRCLE	0	0	0	31,476	194.02
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.03
194.04 07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.04
194.05 07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.05
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	6,335,349	3,048,458	3,503,548		12,722,372

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet B-1

Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00				
203.00	Unit cost multiplier (Wkst. B, Part I)	17.038157	8.198460	0.150775		0.236543	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			24,404		458,594	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001050		0.008527	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet B-1

Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5A.02	5.02	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00560	-4,411,980	58,012,779				5.02
7.00	00700	0	3,707,156	294,154			7.00
8.00	00800	0	417,285	600	531,717		8.00
9.00	00900	0	1,169,070	1,266	0	169,090	9.00
10.00	01000	0	466,153	3,478	0	3,478	10.00
11.00	01100	0	967,895	2,922	0	2,922	11.00
13.00	01300	0	1,803,859	757	0	757	13.00
14.00	01400	0	826,403	2,010	18,568	2,010	14.00
15.00	01500	0	1,603,610	2,510	0	2,510	15.00
16.00	01600	0	1,243,177	2,770	0	2,770	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	6,631,595	42,058	176,393	42,058	30.00
31.00	03100	0	2,098,364	9,401	32,494	9,401	31.00
43.00	04300	0	339,232	900	0	900	43.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	3,584,895	17,505	118,369	17,505	50.00
51.00	05100	0	1,102,622	825	0	825	51.00
52.00	05200	0	786,357	3,442	0	3,442	52.00
53.00	05300	0	574	0	0	0	53.00
54.00	05400	0	3,538,689	13,038	0	13,038	54.00
54.01	05401	0	1	0	0	0	54.01
54.02	05402	0	2,368,520	11,802	6,032	11,802	54.02
56.00	05600	0	383,458	511	48,979	511	56.00
57.00	05700	0	730,066	1,937	0	1,937	57.00
58.00	05800	0	778,333	3,517	0	3,517	58.00
60.00	06000	0	4,272,141	6,095	0	6,095	60.00
65.00	06500	0	935,700	3,023	0	3,023	65.00
66.00	06600	0	2,702,147	8,832	31,681	8,832	66.00
67.00	06700	0	300,794	0	0	0	67.00
68.00	06800	0	32,112	100	0	100	68.00
69.00	06900	0	216,839	50	0	50	69.00
71.00	07100	0	606,132	0	0	0	71.00
72.00	07200	0	2,868,945	0	0	0	72.00
73.00	07300	0	6,644,613	0	0	0	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03610	0	0	0	0	0	76.01
76.02	03550	0	0	0	0	0	76.02
76.03	03951	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	976,802	3,808	9,284	3,708	90.00
91.00	09100	0	2,782,322	13,400	64,987	13,400	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	0	0	0	0	0	116.00
118.00		-4,411,980	56,885,861	156,557	506,787	154,591	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	95,232	615	0	615	190.00
192.00	19200	-4,082,126	0	123,098	0	0	192.00
192.01	19201	0	368,014	11,793	0	11,793	192.01
194.00	07950	0	0	0	10,987	0	194.00
194.01	07951	0	663,672	2,091	0	2,091	194.01
194.02	07952	31,476	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	13,943	0	194.05
200.00							200.00
201.00							201.00
202.00			4,411,980	3,989,093	457,157	1,275,149	202.00
203.00			0.076052	13.561240	0.859775	7.541244	203.00
204.00			764,995	822,296	25,200	59,576	204.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150133		Period: From 03/01/2014 To 02/28/2015		Worksheet B-1 Date/Time Prepared: 7/30/2015 3:14 pm	
Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5A.02	5.02	7.00	8.00	9.00	
205.00	Unit cost multiplier (Wkst. B, Part II)		0.013187	2.795461	0.047394	0.352333	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet B-1  
Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	102,285					11.00
13.00	01300		33,276				13.00
14.00	01400			11,691,769			14.00
15.00	01500				5,301,357		15.00
16.00	01600					5,373,520	16.00
17.00	01700						17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	55,145	6,595	3,245,842	313,097		30.00
31.00	03100	8,203	1,929	1,124,833	81,022		31.00
43.00	04300		279	187,950			43.00
45.00	04500						45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	2,534	2,076	1,270,158	810,759		50.00
51.00	05100		1,036	638,831	52,131		51.00
52.00	05200	9,854	609	410,121			52.00
53.00	05300				464		53.00
54.00	05400		3,304		104,962		54.00
54.01	05401						54.01
54.02	05402		1,252	760,067	45,674		54.02
56.00	05600		207		1,417		56.00
57.00	05700		466		74,677		57.00
58.00	05800		405		3,571		58.00
60.00	06000		3,247	1,260,704	473,203		60.00
65.00	06500		986	491,621	30,167		65.00
66.00	06600		1,676		23,724		66.00
67.00	06700		82		4,471		67.00
68.00	06800				8		68.00
69.00	06900		354	138,919	2,674		69.00
71.00	07100				446,851		71.00
72.00	07200				2,320,135		72.00
73.00	07300					5,373,520	73.00
76.00	03950						76.00
76.01	03610						76.01
76.02	03550						76.02
76.03	03951						76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000		1,219	555,054	111,857		90.00
91.00	09100		2,524	1,355,527	264,174		91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500						95.00
96.00	09600						96.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600						116.00
118.00		75,736	32,921	11,691,769	5,262,745	5,373,520	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000		97		25,129		190.00
192.00	19200				2,911		192.00
192.01	19201						192.01
194.00	07950						194.00
194.01	07951		258		10,572		194.01
194.02	07952	9,285					194.02
194.03	07953	17,264					194.03
194.04	07954						194.04
194.05	07955						194.05
200.00							200.00
201.00							201.00
202.00		574,999	1,103,167	2,008,506	1,016,442	1,830,271	202.00
203.00		5.621538	33.152031	0.171788	0.191732	0.340609	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet B-1

Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	108,216	102,864	63,717	78,546	108,845	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.057985	3.091237	0.005450	0.014816	0.020256	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet B-1  
Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL		5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL		5.02
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	462,338,280	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	40,675,577	30.00
31.00	03100	INTENSIVE CARE UNIT	2,759,991	31.00
43.00	04300	NURSERY	1,380,008	43.00
45.00	04500	NURSING FACILITY	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	51,565,948	50.00
51.00	05100	RECOVERY ROOM	4,915,853	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,011,285	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,646,427	54.00
54.01	05401	ULTRASOUND	0	54.01
54.02	05402	ONCOLOGY	13,991,219	54.02
56.00	05600	RADIOISOTOPE	5,835,527	56.00
57.00	05700	CT SCAN	49,946,657	57.00
58.00	05800	MRI	12,749,234	58.00
60.00	06000	LABORATORY	50,953,863	60.00
65.00	06500	RESPIRATORY THERAPY	9,247,713	65.00
66.00	06600	PHYSICAL THERAPY	6,869,755	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,350,592	67.00
68.00	06800	SPEECH PATHOLOGY	156,588	68.00
69.00	06900	ELECTROCARDIOLOGY	2,906,092	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,453,710	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,620,701	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	122,803,864	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	76.00
76.01	03610	SLEEP LAB	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.02
76.03	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	4,943,849	90.00
91.00	09100	EMERGENCY	31,553,827	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500	AMBULANCE SERVICES	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
116.00	11600	HOSPICE	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	462,338,280	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	WELLNESS CENTER	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07951	MARKETING	0	194.01
194.02	07952	SENIOR CIRCLE	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COST CENTERS	0	194.05
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,441,183	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003117	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet B-1

Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		16.00	17.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	108,245	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000234	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150133		Period: From 03/01/2014 To 02/28/2015		Worksheet C Part I Date/Time Prepared: 7/30/2015 3:14 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		9,448,176	0	9,448,176	30.00	
31.00	03100 INTENSIVE CARE UNIT		2,811,705	0	2,811,705	31.00	
43.00	04300 NURSERY		429,861	0	429,861	43.00	
45.00	04500 NURSING FACILITY		0	0	0	45.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		4,946,149	0	4,946,149	50.00	
51.00	05100 RECOVERY ROOM		1,373,296	0	1,373,296	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,074,221	0	1,074,221	52.00	
53.00	05300 ANESTHESIOLOGY		707	0	707	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,264,493	0	4,264,493	54.00	
54.01	05401 ULTRASOUND		1	0	1	54.01	
54.02	05402 ONCOLOGY		3,027,333	0	3,027,333	54.02	
56.00	05600 RADIOISOTOPE		490,839	0	490,839	56.00	
57.00	05700 CT SCAN		1,011,915	0	1,011,915	57.00	
58.00	05800 MRI		965,596	0	965,596	58.00	
60.00	06000 LABORATORY		5,299,436	0	5,299,436	60.00	
65.00	06500 RESPIRATORY THERAPY	0	1,222,407	0	1,222,407	65.00	
66.00	06600 PHYSICAL THERAPY	0	3,202,792	0	3,202,792	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	331,455	0	331,455	67.00	
68.00	06800 SPEECH PATHOLOGY	0	37,154	0	37,154	68.00	
69.00	06900 ELECTROCARDIOLOGY		279,557	0	279,557	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		779,841	0	779,841	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		3,577,550	0	3,577,550	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		9,363,065	0	9,363,065	73.00	
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.00	
76.01	03610 SLEEP LAB		0	0	0	76.01	
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	76.02	
76.03	03951 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.03	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC		1,311,297	0	1,311,297	90.00	
91.00	09100 EMERGENCY		3,798,114	0	3,798,114	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		2,271,832	0	2,271,832	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00	
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		0	0	0	96.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600 HOSPICE		0	0	0	116.00	
200.00	Subtotal (see instructions)		61,318,792	0	61,318,792	200.00	
201.00	Less Observation Beds		2,271,832	0	2,271,832	201.00	
202.00	Total (see instructions)		59,046,960	0	59,046,960	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet C  
Part I  
Date/Time Prepared:  
7/30/2015 3:14 pm

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	33,034,162		33,034,162		30.00
31.00	03100	INTENSIVE CARE UNIT	2,759,991		2,759,991		31.00
43.00	04300	NURSERY	1,380,008		1,380,008		43.00
45.00	04500	NURSING FACILITY	0		0		45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	15,715,456	35,850,492	51,565,948	0.095919	50.00
51.00	05100	RECOVERY ROOM	1,583,302	3,332,551	4,915,853	0.279361	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,732,861	278,424	3,011,285	0.356732	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,147,235	13,499,192	16,646,427	0.256181	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	54.01
54.02	05402	ONCOLOGY	75,723	13,915,496	13,991,219	0.216374	54.02
56.00	05600	RADIOLOGY	464,862	5,370,665	5,835,527	0.084112	56.00
57.00	05700	CT SCAN	6,765,448	43,181,209	49,946,657	0.020260	57.00
58.00	05800	MRI	769,644	11,979,590	12,749,234	0.075738	58.00
60.00	06000	LABORATORY	13,629,629	37,324,234	50,953,863	0.104005	60.00
65.00	06500	RESPIRATORY THERAPY	3,951,397	5,296,316	9,247,713	0.132185	65.00
66.00	06600	PHYSICAL THERAPY	865,500	6,004,255	6,869,755	0.466216	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,958	1,291,634	1,350,592	0.245415	67.00
68.00	06800	SPEECH PATHOLOGY	68,492	88,096	156,588	0.237272	68.00
69.00	06900	ELECTROCARDIOLOGY	48,500	2,857,592	2,906,092	0.096197	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,888,818	8,564,892	13,453,710	0.057965	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,210,976	6,409,725	14,620,701	0.244691	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,046,524	80,757,340	122,803,864	0.076244	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	76.02
76.03	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	588,597	4,355,252	4,943,849	0.265238	90.00
91.00	09100	EMERGENCY	5,488,016	26,065,811	31,553,827	0.120369	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,346,894	5,294,521	7,641,415	0.297305	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	150,620,993	311,717,287	462,338,280		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	150,620,993	311,717,287	462,338,280		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet C Part I Date/Time Prepared: 7/30/2015 3:14 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
45.00	04500 NURSING FACILITY			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.095919		50.00
51.00	05100 RECOVERY ROOM	0.279361		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.356732		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.256181		54.00
54.01	05401 ULTRASOUND	0.000000		54.01
54.02	05402 ONCOLOGY	0.216374		54.02
56.00	05600 RADIOISOTOPE	0.084112		56.00
57.00	05700 CT SCAN	0.020260		57.00
58.00	05800 MRI	0.075738		58.00
60.00	06000 LABORATORY	0.104005		60.00
65.00	06500 RESPIRATORY THERAPY	0.132185		65.00
66.00	06600 PHYSICAL THERAPY	0.466216		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.245415		67.00
68.00	06800 SPEECH PATHOLOGY	0.237272		68.00
69.00	06900 ELECTROCARDIOLOGY	0.096197		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.057965		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.244691		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.076244		73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.01	03610 SLEEP LAB	0.000000		76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.02
76.03	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.265238		90.00
91.00	09100 EMERGENCY	0.120369		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.297305		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet C  
Part I  
Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	9,448,176		9,448,176	0	9,448,176 30.00
31.00	03100 INTENSIVE CARE UNIT	2,811,705		2,811,705	0	2,811,705 31.00
43.00	04300 NURSERY	429,861		429,861	0	429,861 43.00
45.00	04500 NURSING FACILITY	0		0	0	0 45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	4,946,149		4,946,149	0	4,946,149 50.00
51.00	05100 RECOVERY ROOM	1,373,296		1,373,296	0	1,373,296 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,074,221		1,074,221	0	1,074,221 52.00
53.00	05300 ANESTHESIOLOGY	707		707	0	707 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,264,493		4,264,493	0	4,264,493 54.00
54.01	05401 ULTRASOUND	1		1	0	1 54.01
54.02	05402 ONCOLOGY	3,027,333		3,027,333	0	3,027,333 54.02
56.00	05600 RADIOISOTOPE	490,839		490,839	0	490,839 56.00
57.00	05700 CT SCAN	1,011,915		1,011,915	0	1,011,915 57.00
58.00	05800 MRI	965,596		965,596	0	965,596 58.00
60.00	06000 LABORATORY	5,299,436		5,299,436	0	5,299,436 60.00
65.00	06500 RESPIRATORY THERAPY	1,222,407	0	1,222,407	0	1,222,407 65.00
66.00	06600 PHYSICAL THERAPY	3,202,792	0	3,202,792	0	3,202,792 66.00
67.00	06700 OCCUPATIONAL THERAPY	331,455	0	331,455	0	331,455 67.00
68.00	06800 SPEECH PATHOLOGY	37,154	0	37,154	0	37,154 68.00
69.00	06900 ELECTROCARDIOLOGY	279,557		279,557	0	279,557 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	779,841		779,841	0	779,841 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,577,550		3,577,550	0	3,577,550 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	9,363,065		9,363,065	0	9,363,065 73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0 76.00
76.01	03610 SLEEP LAB	0		0	0	0 76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		0	0	0 76.02
76.03	03951 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	1,311,297		1,311,297	0	1,311,297 90.00
91.00	09100 EMERGENCY	3,798,114		3,798,114	0	3,798,114 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,271,832		2,271,832	0	2,271,832 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	0		0	0	0 95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0 96.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00	11600 HOSPICE	0		0	0	0 116.00
200.00	Subtotal (see instructions)	61,318,792	0	61,318,792	0	61,318,792 200.00
201.00	Less Observation Beds	2,271,832		2,271,832	0	2,271,832 201.00
202.00	Total (see instructions)	59,046,960	0	59,046,960	0	59,046,960 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet C  
Part I  
Date/Time Prepared:  
7/30/2015 3:14 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	33,034,162		33,034,162		30.00
31.00	03100	INTENSIVE CARE UNIT	2,759,991		2,759,991		31.00
43.00	04300	NURSERY	1,380,008		1,380,008		43.00
45.00	04500	NURSING FACILITY	0		0		45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	15,715,456	35,850,492	51,565,948	0.095919	50.00
51.00	05100	RECOVERY ROOM	1,583,302	3,332,551	4,915,853	0.279361	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,732,861	278,424	3,011,285	0.356732	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,147,235	13,499,192	16,646,427	0.256181	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	54.01
54.02	05402	ONCOLOGY	75,723	13,915,496	13,991,219	0.216374	54.02
56.00	05600	RADIOLOGY	464,862	5,370,665	5,835,527	0.084112	56.00
57.00	05700	CT SCAN	6,765,448	43,181,209	49,946,657	0.020260	57.00
58.00	05800	MRI	769,644	11,979,590	12,749,234	0.075738	58.00
60.00	06000	LABORATORY	13,629,629	37,324,234	50,953,863	0.104005	60.00
65.00	06500	RESPIRATORY THERAPY	3,951,397	5,296,316	9,247,713	0.132185	65.00
66.00	06600	PHYSICAL THERAPY	865,500	6,004,255	6,869,755	0.466216	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,958	1,291,634	1,350,592	0.245415	67.00
68.00	06800	SPEECH PATHOLOGY	68,492	88,096	156,588	0.237272	68.00
69.00	06900	ELECTROCARDIOLOGY	48,500	2,857,592	2,906,092	0.096197	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,888,818	8,564,892	13,453,710	0.057965	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,210,976	6,409,725	14,620,701	0.244691	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,046,524	80,757,340	122,803,864	0.076244	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	76.02
76.03	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	588,597	4,355,252	4,943,849	0.265238	90.00
91.00	09100	EMERGENCY	5,488,016	26,065,811	31,553,827	0.120369	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,346,894	5,294,521	7,641,415	0.297305	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	150,620,993	311,717,287	462,338,280		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	150,620,993	311,717,287	462,338,280		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet C Part I Date/Time Prepared: 7/30/2015 3:14 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
45.00	04500 NURSING FACILITY			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 ULTRASOUND	0.000000		54.01
54.02	05402 ONCOLOGY	0.000000		54.02
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.01	03610 SLEEP LAB	0.000000		76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.02
76.03	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet C  
Part I  
Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	9,448,176		9,448,176	0	9,448,176 30.00
31.00	03100 INTENSIVE CARE UNIT	2,811,705		2,811,705	0	2,811,705 31.00
43.00	04300 NURSERY	429,861		429,861	0	429,861 43.00
45.00	04500 NURSING FACILITY	0		0	0	0 45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	4,946,149		4,946,149	0	4,946,149 50.00
51.00	05100 RECOVERY ROOM	1,373,296		1,373,296	0	1,373,296 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,074,221		1,074,221	0	1,074,221 52.00
53.00	05300 ANESTHESIOLOGY	707		707	0	707 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,264,493		4,264,493	0	4,264,493 54.00
54.01	05401 ULTRASOUND	1		1	0	1 54.01
54.02	05402 ONCOLOGY	3,027,333		3,027,333	0	3,027,333 54.02
56.00	05600 RADIOISOTOPE	490,839		490,839	0	490,839 56.00
57.00	05700 CT SCAN	1,011,915		1,011,915	0	1,011,915 57.00
58.00	05800 MRI	965,596		965,596	0	965,596 58.00
60.00	06000 LABORATORY	5,299,436		5,299,436	0	5,299,436 60.00
65.00	06500 RESPIRATORY THERAPY	1,222,407	0	1,222,407	0	1,222,407 65.00
66.00	06600 PHYSICAL THERAPY	3,202,792	0	3,202,792	0	3,202,792 66.00
67.00	06700 OCCUPATIONAL THERAPY	331,455	0	331,455	0	331,455 67.00
68.00	06800 SPEECH PATHOLOGY	37,154	0	37,154	0	37,154 68.00
69.00	06900 ELECTROCARDIOLOGY	279,557		279,557	0	279,557 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	779,841		779,841	0	779,841 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,577,550		3,577,550	0	3,577,550 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	9,363,065		9,363,065	0	9,363,065 73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0 76.00
76.01	03610 SLEEP LAB	0		0	0	0 76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		0	0	0 76.02
76.03	03951 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	1,311,297		1,311,297	0	1,311,297 90.00
91.00	09100 EMERGENCY	3,798,114		3,798,114	0	3,798,114 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,271,832		2,271,832	0	2,271,832 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	0		0	0	0 95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0 96.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00	11600 HOSPICE	0		0	0	0 116.00
200.00	Subtotal (see instructions)	61,318,792	0	61,318,792	0	61,318,792 200.00
201.00	Less Observation Beds	2,271,832		2,271,832	0	2,271,832 201.00
202.00	Total (see instructions)	59,046,960	0	59,046,960	0	59,046,960 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet C  
Part I  
Date/Time Prepared:  
7/30/2015 3:14 pm

		Title V			Hospital	Cost		
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	33,034,162		33,034,162			30.00
31.00	03100	INTENSIVE CARE UNIT	2,759,991		2,759,991			31.00
43.00	04300	NURSERY	1,380,008		1,380,008			43.00
45.00	04500	NURSING FACILITY	0		0			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	15,715,456	35,850,492	51,565,948	0.095919	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,583,302	3,332,551	4,915,853	0.279361	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,732,861	278,424	3,011,285	0.356732	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,147,235	13,499,192	16,646,427	0.256181	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
54.02	05402	ONCOLOGY	75,723	13,915,496	13,991,219	0.216374	0.000000	54.02
56.00	05600	RADIOLOGY	464,862	5,370,665	5,835,527	0.084112	0.000000	56.00
57.00	05700	CT SCAN	6,765,448	43,181,209	49,946,657	0.020260	0.000000	57.00
58.00	05800	MRI	769,644	11,979,590	12,749,234	0.075738	0.000000	58.00
60.00	06000	LABORATORY	13,629,629	37,324,234	50,953,863	0.104005	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,951,397	5,296,316	9,247,713	0.132185	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	865,500	6,004,255	6,869,755	0.466216	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,958	1,291,634	1,350,592	0.245415	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	68,492	88,096	156,588	0.237272	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	48,500	2,857,592	2,906,092	0.096197	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,888,818	8,564,892	13,453,710	0.057965	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,210,976	6,409,725	14,620,701	0.244691	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,046,524	80,757,340	122,803,864	0.076244	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.02
76.03	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	588,597	4,355,252	4,943,849	0.265238	0.000000	90.00
91.00	09100	EMERGENCY	5,488,016	26,065,811	31,553,827	0.120369	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,346,894	5,294,521	7,641,415	0.297305	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	150,620,993	311,717,287	462,338,280			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	150,620,993	311,717,287	462,338,280			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet C Part I Date/Time Prepared: 7/30/2015 3:14 pm
--	--	----------------------	---	---

Cost Center Description		PPS Inpatient Ratio	Title V	Hospital	Cost
INPATIENT ROUTINE SERVICE COST CENTERS		11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
45.00	04500 NURSING FACILITY				45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401 ULTRASOUND	0.000000			54.01
54.02	05402 ONCOLOGY	0.000000			54.02
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MRI	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000			76.00
76.01	03610 SLEEP LAB	0.000000			76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.02
76.03	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150133		Period: From 03/01/2014 To 02/28/2015		Worksheet D Part I Date/Time Prepared: 7/30/2015 3:14 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	1,449,322	0	1,449,322	12,435	116.55	30.00
31.00	INTENSIVE CARE UNIT	334,322		334,322	1,297	257.77	31.00
43.00	NURSERY	34,764		34,764	1,264	27.50	43.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	1,818,408		1,818,408	14,996		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	3,593	418,764				
31.00	INTENSIVE CARE UNIT	520	134,040				
43.00	NURSERY	0	0				
45.00	NURSING FACILITY	0	0				
200.00	Total (lines 30-199)	4,113	552,804				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet D Part II Date/Time Prepared: 7/30/2015 3:14 pm
--	--	----------------------	---	--

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	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	615,907	51,565,948	0.011944	3,633,681	43,401	50.00
51.00	05100 RECOVERY ROOM	54,839	4,915,853	0.011156	390,909	4,361	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	129,171	3,011,285	0.042896	7,090	304	52.00
53.00	05300 ANESTHESIOLOGY	19	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	458,602	16,646,427	0.027550	2,728,433	75,168	54.00
54.01	05401 ULTRASOUND	0	0	0.000000	0	0	54.01
54.02	05402 ONCOLOGY	395,606	13,991,219	0.028275	38,613	1,092	54.02
56.00	05600 RADIOISOTOPE	26,702	5,835,527	0.004576	254,958	1,167	56.00
57.00	05700 CT SCAN	84,135	49,946,657	0.001684	3,652,771	6,151	57.00
58.00	05800 MRI	119,993	12,749,234	0.009412	372,386	3,505	58.00
60.00	06000 LABORATORY	295,966	50,953,863	0.005809	6,358,597	36,937	60.00
65.00	06500 RESPIRATORY THERAPY	113,451	9,247,713	0.012268	1,995,347	24,479	65.00
66.00	06600 PHYSICAL THERAPY	314,259	6,869,755	0.045745	347,283	15,886	66.00
67.00	06700 OCCUPATIONAL THERAPY	6,699	1,350,592	0.004960	33,670	167	67.00
68.00	06800 SPEECH PATHOLOGY	3,520	156,588	0.022479	48,499	1,090	68.00
69.00	06900 ELECTROCARDIOLOGY	8,491	2,906,092	0.002922	28,002	82	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21,942	13,453,710	0.001631	1,530,669	2,497	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	95,415	14,620,701	0.006526	2,667,112	17,406	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	271,033	122,803,864	0.002207	15,880,414	35,048	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01	03610 SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
76.03	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	138,299	4,943,849	0.027974	135,187	3,782	90.00
91.00	09100 EMERGENCY	467,217	31,553,827	0.014807	2,414,112	35,746	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	348,492	7,641,415	0.045606	923,650	42,124	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00	Total (lines 50-199)	3,969,758	425,164,119		43,441,383	350,393	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150133		Period: From 03/01/2014 To 02/28/2015		Worksheet D Part III Date/Time Prepared: 7/30/2015 3:14 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,435	0.00	3,593	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,297	0.00	520	0		31.00
43.00	04300	NURSERY	1,264	0.00	0	0		43.00
45.00	04500	NURSING FACILITY	0	0.00	0	0		45.00
200.00		Total (lines 30-199)	14,996		4,113	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet D Part IV Date/Time Prepared: 7/30/2015 3:14 pm
--	----------------------	---	--

Cost Center Description		Title XVIII				Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00	
54.01	05401	ULTRASOUND	0	0	0	0	54.01	
54.02	05402	ONCOLOGY	0	0	0	0	54.02	
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00	
57.00	05700	CT SCAN	0	0	0	0	57.00	
58.00	05800	MRI	0	0	0	0	58.00	
60.00	06000	LABORATORY	0	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00	
76.01	03610	SLEEP LAB	0	0	0	0	76.01	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.02	
76.03	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.03	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES					95.00	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00	
200.00		Total (lines 50-199)	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet D Part IV Date/Time Prepared: 7/30/2015 3:14 pm
--	----------------------	---------------------------------------	---

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		
Title XVIII Hospital PPS								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	51,565,948	0.000000	0.000000	3,633,681	50.00
51.00	05100	RECOVERY ROOM	0	4,915,853	0.000000	0.000000	390,909	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,011,285	0.000000	0.000000	7,090	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,646,427	0.000000	0.000000	2,728,433	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
54.02	05402	ONCOLOGY	0	13,991,219	0.000000	0.000000	38,613	54.02
56.00	05600	RADIOISOTOPE	0	5,835,527	0.000000	0.000000	254,958	56.00
57.00	05700	CT SCAN	0	49,946,657	0.000000	0.000000	3,652,771	57.00
58.00	05800	MRI	0	12,749,234	0.000000	0.000000	372,386	58.00
60.00	06000	LABORATORY	0	50,953,863	0.000000	0.000000	6,358,597	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,247,713	0.000000	0.000000	1,995,347	65.00
66.00	06600	PHYSICAL THERAPY	0	6,869,755	0.000000	0.000000	347,283	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,350,592	0.000000	0.000000	33,670	67.00
68.00	06800	SPEECH PATHOLOGY	0	156,588	0.000000	0.000000	48,499	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,906,092	0.000000	0.000000	28,002	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,453,710	0.000000	0.000000	1,530,669	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,620,701	0.000000	0.000000	2,667,112	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	122,803,864	0.000000	0.000000	15,880,414	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0.000000	0	76.02
76.03	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	4,943,849	0.000000	0.000000	135,187	90.00
91.00	09100	EMERGENCY	0	31,553,827	0.000000	0.000000	2,414,112	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,641,415	0.000000	0.000000	923,650	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	425,164,119			43,441,383	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet D Part IV Date/Time Prepared: 7/30/2015 3:14 pm
--	----------------------	---	--

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	4,182,166	0	50.00
51.00	05100 RECOVERY ROOM	0	303,580	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	210	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	4,958,079	0	54.00
54.01	05401 ULTRASOUND	0	0	0	54.01
54.02	05402 ONCOLOGY	0	4,030,298	0	54.02
56.00	05600 RADIOISOTOPE	0	1,333,193	0	56.00
57.00	05700 CT SCAN	0	7,203,160	0	57.00
58.00	05800 MRI	0	2,118,534	0	58.00
60.00	06000 LABORATORY	0	4,028,731	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,006,739	0	65.00
66.00	06600 PHYSICAL THERAPY	0	13,168	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	636	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	770,724	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	855,295	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	631,290	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	18,404,076	0	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.01	03610 SLEEP LAB	0	0	0	76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	76.02
76.03	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	580,678	0	90.00
91.00	09100 EMERGENCY	0	3,670,708	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1,039,349	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00	Total (lines 50-199)	0	55,130,614	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet D Part V Date/Time Prepared: 7/30/2015 3:14 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.095919	4,182,166	0	0	401,149	50.00
51.00	05100	RECOVERY ROOM	0.279361	303,580	0	0	84,808	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.356732	210	0	0	75	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256181	4,958,079	0	0	1,270,166	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0.216374	4,030,298	0	0	872,052	54.02
56.00	05600	RADIOISOTOPE	0.084112	1,333,193	0	0	112,138	56.00
57.00	05700	CT SCAN	0.020260	7,203,160	0	0	145,936	57.00
58.00	05800	MRI	0.075738	2,118,534	0	0	160,454	58.00
60.00	06000	LABORATORY	0.104005	4,028,731	0	3,994	419,008	60.00
65.00	06500	RESPIRATORY THERAPY	0.132185	1,006,739	0	0	133,076	65.00
66.00	06600	PHYSICAL THERAPY	0.466216	13,168	0	0	6,139	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.245415	636	0	0	156	67.00
68.00	06800	SPEECH PATHOLOGY	0.237272	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.096197	770,724	0	0	74,141	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.057965	855,295	0	0	49,577	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.244691	631,290	0	0	154,471	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.076244	18,404,076	0	54,027	1,403,200	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.265238	580,678	0	0	154,018	90.00
91.00	09100	EMERGENCY	0.120369	3,670,708	0	0	441,839	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.297305	1,039,349	0	0	309,004	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		55,130,614	0	58,021	6,191,407	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		55,130,614	0	58,021	6,191,407	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet D Part V Date/Time Prepared: 7/30/2015 3:14 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 ULTRASOUND	0	0		54.01
54.02 05402 ONCOLOGY	0	0		54.02
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
60.00 06000 LABORATORY	0	415		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4,119		73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01 03610 SLEEP LAB	0	0		76.01
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	0	4,534		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	4,534		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet D Part V Date/Time Prepared: 7/30/2015 3:14 pm
		Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.095919	0	0	870,224	0	50.00
51.00	05100 RECOVERY ROOM	0.279361	0	0	95,593	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.356732	0	0	20,753	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.256181	0	0	1,070,343	0	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0	54.01
54.02	05402 ONCOLOGY	0.216374	0	0	629,662	0	54.02
56.00	05600 RADIOISOTOPE	0.084112	0	0	166,954	0	56.00
57.00	05700 CT SCAN	0.020260	0	0	1,946,846	0	57.00
58.00	05800 MRI	0.075738	0	0	506,701	0	58.00
60.00	06000 LABORATORY	0.104005	0	0	1,738,294	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.132185	0	0	254,502	0	65.00
66.00	06600 PHYSICAL THERAPY	0.466216	0	0	119,990	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.245415	0	0	34,039	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.237272	0	0	8,802	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.096197	0	0	109,088	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.057965	0	0	225,124	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.244691	0	0	179,414	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.076244	0	0	2,934,656	0	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03610 SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.265238	0	0	164,732	0	90.00
91.00	09100 EMERGENCY	0.120369	0	0	1,804,078	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.297305	0	0	280,854	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00	Subtotal (see instructions)		0	0	13,160,649	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	13,160,649	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet D Part V Date/Time Prepared: 7/30/2015 3:14 pm
	Title XIX	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	83,471	50.00
51.00	05100	RECOVERY ROOM	0	26,705	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,403	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	274,202	54.00
54.01	05401	ULTRASOUND	0	0	54.01
54.02	05402	ONCOLOGY	0	136,242	54.02
56.00	05600	RADIOISOTOPE	0	14,043	56.00
57.00	05700	CT SCAN	0	39,443	57.00
58.00	05800	MRI	0	38,377	58.00
60.00	06000	LABORATORY	0	180,791	60.00
65.00	06500	RESPIRATORY THERAPY	0	33,641	65.00
66.00	06600	PHYSICAL THERAPY	0	55,941	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,354	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,088	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,494	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,049	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	43,901	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	223,750	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	43,693	90.00
91.00	09100	EMERGENCY	0	217,155	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	83,499	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	0	1,536,242	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	1,536,242	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet D-1 Date/Time Prepared: 7/30/2015 3:14 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,435	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,435	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		9,445	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,593	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,448,176	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		9,448,176	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		9,448,176	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		759.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,729,997	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,729,997	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150133		Period: From 03/01/2014 To 02/28/2015		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 7/30/2015 3:14 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	2,811,705	1,297	2,167.85	520	1,127,282		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,953,885		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,811,164		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)					552,804		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					350,393		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					903,197		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,907,967		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/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					2,990		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					759.81		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,271,832		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150133		Period: From 03/01/2014 To 02/28/2015		Worksheet D-1 Date/Time Prepared: 7/30/2015 3:14 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,449,322	9,448,176	0.153397	2,271,832	348,492	90.00
91.00	Nursing School cost	0	9,448,176	0.000000	2,271,832	0	91.00
92.00	Allied health cost	0	9,448,176	0.000000	2,271,832	0	92.00
93.00	All other Medical Education	0	9,448,176	0.000000	2,271,832	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet D-3 Date/Time Prepared: 7/30/2015 3:14 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		7,478,562	30.00
31.00	03100	INTENSIVE CARE UNIT		1,639,969	31.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.095919	3,633,681	348,539 50.00
51.00	05100	RECOVERY ROOM	0.279361	390,909	109,205 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.356732	7,090	2,529 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256181	2,728,433	698,973 54.00
54.01	05401	ULTRASOUND	0.000000	0	0 54.01
54.02	05402	ONCOLOGY	0.216374	38,613	8,355 54.02
56.00	05600	RADIOISOTOPE	0.084112	254,958	21,445 56.00
57.00	05700	CT SCAN	0.020260	3,652,771	74,005 57.00
58.00	05800	MRI	0.075738	372,386	28,204 58.00
60.00	06000	LABORATORY	0.104005	6,358,597	661,326 60.00
65.00	06500	RESPIRATORY THERAPY	0.132185	1,995,347	263,755 65.00
66.00	06600	PHYSICAL THERAPY	0.466216	347,283	161,909 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.245415	33,670	8,263 67.00
68.00	06800	SPEECH PATHOLOGY	0.237272	48,499	11,507 68.00
69.00	06900	ELECTROCARDIOLOGY	0.096197	28,002	2,694 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.057965	1,530,669	88,725 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.244691	2,667,112	652,618 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.076244	15,880,414	1,210,786 73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.00
76.01	03610	SLEEP LAB	0.000000	0	0 76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0 76.02
76.03	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.265238	135,187	35,857 90.00
91.00	09100	EMERGENCY	0.120369	2,414,112	290,584 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.297305	923,650	274,606 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0 96.00
200.00		Total (sum of lines 50-94 and 96-98)		43,441,383	4,953,885 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		43,441,383	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet D-3 Date/Time Prepared: 7/30/2015 3:14 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		873,787	30.00
31.00	03100	INTENSIVE CARE UNIT		244,088	31.00
43.00	04300	NURSERY		140,841	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.095919	742,767	50.00
51.00	05100	RECOVERY ROOM	0.279361	81,292	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.356732	118,004	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256181	201,149	54.00
54.01	05401	ULTRASOUND	0.000000	0	54.01
54.02	05402	ONCOLOGY	0.216374	16,082	54.02
56.00	05600	RADIOISOTOPE	0.084112	24,220	56.00
57.00	05700	CT SCAN	0.020260	377,980	57.00
58.00	05800	MRI	0.075738	49,674	58.00
60.00	06000	LABORATORY	0.104005	721,650	60.00
65.00	06500	RESPIRATORY THERAPY	0.132185	171,477	65.00
66.00	06600	PHYSICAL THERAPY	0.466216	31,345	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.245415	809	67.00
68.00	06800	SPEECH PATHOLOGY	0.237272	2,474	68.00
69.00	06900	ELECTROCARDIOLOGY	0.096197	5,904	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.057965	225,189	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.244691	287,583	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.076244	2,345,107	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	76.02
76.03	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.265238	26,003	90.00
91.00	09100	EMERGENCY	0.120369	285,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.297305	93,378	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		5,807,802	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)		5,807,802	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet E Part A Date/Time Prepared: 7/30/2015 3:14 pm	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>					
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		3,874,245		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,511,968		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0		1.04
2.00	Outlier payments for discharges. (see instructions)		33,097		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		63.81		4.00
<b>Indirect Medical Education Adjustment</b>					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment ( sum of lines 22 and 28)		0		29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet E Part A Date/Time Prepared: 7/30/2015 3:14 pm		
		Title XVIII	Hospital		PPS	
		0	before 1/1	on/after 1/1	2.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		1.00	1.01		29.01
<b>Disproportionate Share Adjustment</b>						
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.36			30.00
31.00	Percentage of Medicaid patient days (see instructions)		16.81			31.00
32.00	Sum of lines 30 and 31		18.17			32.00
33.00	Allowable disproportionate share percentage (see instructions)		4.56			33.00
34.00	Disproportionate share adjustment (see instructions)		72,804			34.00
			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
<b>Uncompensated Care Adjustment</b>						
35.00	Total uncompensated care amount (see instructions)		9,046,380,143		7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000072798		0.000071950	35.01
35.02	Hospital uncompensated care payment (if line 34 is zero, enter zero on this line) (see instructions)		658,558		550,234	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		386,113		227,631	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		613,744			36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>						
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0			46.00
47.00	Subtotal (see instructions)		7,105,858			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0			48.00
49.00	Total payment for inpatient operating costs (see instructions)		7,105,858			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		513,356			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		7,619,214			59.00
60.00	Primary payer payments		3,784			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		7,615,430			61.00
62.00	Deductibles billed to program beneficiaries		1,003,088			62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet E Part A Date/Time Prepared: 7/30/2015 3:14 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00
63.00	Coinsurance billed to program beneficiaries		9,120		63.00
64.00	Allowable bad debts (see instructions)		-63,174		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		-41,063		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		-84,844		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		6,562,159		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		9,168		70.93
70.94	HRR adjustment amount (see instructions)		-48,958		70.94
70.95	Recovery of accelerated depreciation		0		70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,522,369		71.00
71.01	Sequestration adjustment (see instructions)		130,447		71.01
72.00	Interim payments		6,450,528		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-58,606		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,366,012		75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet E Part A Date/Time Prepared: 7/30/2015 3:14 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1		On/After 10/1
		1.00	1.01	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)	0		0 100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0		0 101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0		0 102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000		0.0000 103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0		0 104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet E Part B Date/Time Prepared: 7/30/2015 3:14 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		4,534	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,191,407	2.00
3.00	PPS payments		5,962,870	3.00
4.00	Outlier payment (see instructions)		10,933	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)		4,534	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		58,021	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		58,021	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		58,021	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		53,487	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)		4,534	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		5,973,803	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		360	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,305,311	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} (for CAH, see instructions)		4,672,666	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		4,672,666	30.00
31.00	Primary payer payments		503	31.00
32.00	Subtotal (line 30 minus line 31)		4,672,163	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		30,917	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		20,096	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		17,656	36.00
37.00	Subtotal (see instructions)		4,692,259	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		4,692,259	40.00
40.01	Sequestration adjustment (see instructions)		93,845	40.01
41.00	Interim payments		4,714,880	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-116,466	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 150133		Period: From 03/01/2014 To 02/28/2015		Worksheet E-1 Part I Date/Time Prepared: 7/30/2015 3:14 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		6,368,191		4,577,206	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	02/28/2015	35,437	02/28/2015	88,374	3.01	
3.02		02/28/2015	46,900	02/28/2015	49,300	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)		82,337		137,674	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)		6,450,528		4,714,880	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		58,606		116,466	6.02	
7.00	Total Medicare program liability (see instructions)		6,391,922		4,598,414	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
			0	1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet E-1 Part II Date/Time Prepared: 7/30/2015 3:14 pm
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		3,486	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		4,113	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		2,237	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		10,742	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		462,338,280	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		1,192,602	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		731,214	8.00
9.00	Sequestration adjustment amount (see instructions)		14,624	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		716,590	10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)		701,685	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		14,905	32.00

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

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet G

Date/Time Prepared:  
7/30/2015 3:14 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	-504,782	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	34,518,918	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,788,036	0	0	0	6.00
7.00	Inventory	1,769,358	0	0	0	7.00
8.00	Prepaid expenses	897,701	0	0	0	8.00
9.00	Other current assets	227,400	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)	22,120,559	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	2,769,169	0	0	0	12.00
13.00	Land improvements	1,122,286	0	0	0	13.00
14.00	Accumulated depreciation	-587,580	0	0	0	14.00
15.00	Buildings	35,723,757	0	0	0	15.00
16.00	Accumulated depreciation	-7,675,200	0	0	0	16.00
17.00	Leasehold improvements	13,778,748	0	0	0	17.00
18.00	Accumulated depreciation	-3,365,389	0	0	0	18.00
19.00	Fixed equipment	2,297,670	0	0	0	19.00
20.00	Accumulated depreciation	-1,153,899	0	0	0	20.00
21.00	Automobiles and trucks	110,970	0	0	0	21.00
22.00	Accumulated depreciation	-84,124	0	0	0	22.00
23.00	Major movable equipment	17,874,847	0	0	0	23.00
24.00	Accumulated depreciation	-12,874,677	0	0	0	24.00
25.00	Minor equipment depreciable	5,198,691	0	0	0	25.00
26.00	Accumulated depreciation	-3,271,963	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)	49,863,306	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	2,054,387	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,054,387	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	74,038,252	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	2,103,737	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,084,526	0	0	0	38.00
39.00	Payroll taxes payable	197,375	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	-254,095,511	0	0	0	43.00
44.00	Other current liabilities	1,524,624	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-247,185,249	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
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	2,146,497	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,146,497	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-245,038,752	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	319,077,004				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)	319,077,004	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	74,038,252	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet G-1

Date/Time Prepared:  
7/30/2015 3:14 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		271,306,253		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		47,770,751			2.00
3.00	Total (sum of line 1 and line 2)		319,077,004		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		319,077,004		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		319,077,004		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: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
7/30/2015 3:14 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	19,809,884		19,809,884	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	19,809,884		19,809,884	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,759,991		2,759,991	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	2,759,991		2,759,991	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	22,569,875		22,569,875	17.00
18.00	Ancillary services	112,048,332		112,048,332	18.00
19.00	Outpatient services	0	327,720,073	327,720,073	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	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)	134,618,207	327,720,073	462,338,280	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		89,875,124		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)		89,875,124		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150133

Period:  
From 03/01/2014  
To 02/28/2015

Worksheet G-3

Date/Time Prepared:  
7/30/2015 3:14 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	462,338,280	1.00
2.00	Less contractual allowances and discounts on patients' accounts	326,215,089	2.00
3.00	Net patient revenues (line 1 minus line 2)	136,123,191	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	89,875,124	4.00
5.00	Net income from service to patients (line 3 minus line 4)	46,248,067	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,522,684	24.00
25.00	Total other income (sum of lines 6-24)	1,522,684	25.00
26.00	Total (line 5 plus line 25)	47,770,751	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)	47,770,751	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150133	Period: From 03/01/2014 To 02/28/2015	Worksheet L Parts I-III Date/Time Prepared: 7/30/2015 3:14 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		506,268	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		7,088	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		29.43	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		513,356	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00