

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: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/23/2015 7:20 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 11/23/2015 Time: 7:20 am	
	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.		
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 MARION GENERAL HOSPITAL (150011) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-453,221	182,920	352,991	-491,991	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	-18,229	0	0	34,625	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	-471,450	182,920	352,991	-457,366	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: 150011		Period: From 07/01/2014 To 06/30/2015		Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 7:14 am					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 441 WABASH AVENUE			PO Box:						1.00	
2.00	City: MARION			State: IN		Zip Code: 46952-		County: GRANT		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
		V		XVIII		XIX					
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		MARION GENERAL HOSPITAL	150011	99915	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF		MARION GENERAL HOSPITAL	15T011	99915	5	07/01/2005	N	P	0	5.00
6.00	Subprovider - (Other)		REHAB								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)						07/01/2014	06/30/2015		20.00	
21.00	Type of Control (see instructions)						2		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		N	23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPFS 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.	1,549	999	0	0	2,226	0		24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	115	3	0	0	48			25.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 7:14 am			
		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.		1			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.	07/01/2014	06/30/2015		36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.		0		37.00		
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.				38.00		
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N		39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N		40.00		
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-2
Part I
Date/Time Prepared:
11/23/2015 7:14 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0
					1.00	
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.				N	87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	97.00	
Rural Providers						
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.				N	110.00
					1.00	
					2.00	
					3.00	
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00	
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	793,690	0	0	118.01	
					1.00	
					2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	Y	Y		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 7:14 am		
		1.00	2.00			
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00
		1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00
142.00	Street:	PO Box:				142.00
143.00	City:	State:		Zip Code:		143.00
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00
		1.00		2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00
				1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	
156.00	Subprovider - IPF	N	N	N	N	
157.00	Subprovider - IRF	N	N	N	N	
158.00	SUBPROVIDER					
159.00	SNF	N	N	N	N	
160.00	HOME HEALTH AGENCY	N	N	N	N	
161.00	CMHC		N	N	N	
				1.00		
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00
				1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.75				169.00
		Beginni ng		Endi ng		
		1.00		2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2014		09/30/2014		170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 7:14 am	
				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: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 11/23/2015 7:14 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	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)	Y	10/14/2015	Y	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: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-2
Part II
Date/Time Prepared:
11/23/2015 7:14 am

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA		SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEANDCO.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		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)	10/14/2015	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
11/23/2015 7:14 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	78	28,470	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)		78	28,470	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	19	6,935	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)		97	35,405	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	18	6,570		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		115				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: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
11/23/2015 7:14 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,834	1,549	14,339			1.00
2.00 HMO and other (see instructions)	2,178	3,225				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	131	51				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)	6,834	1,549	14,339			7.00
8.00 INTENSIVE CARE UNIT	1,588	0	3,722			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		0	1,945			13.00
14.00 Total (see instructions)	8,422	1,549	20,006	0.00	772.04	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF	2,646	115	3,240	0.00	19.86	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
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	791.90	27.00
28.00 Observation Bed Days		1,110	3,259			28.00
29.00 Ambulance Trips	1,449					29.00
30.00 Employee discount days (see instruction)			233			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: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
11/23/2015 7:14 am

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	1,990	397	4,998	1.00
2.00 HMO and other (see instructions)			490	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,990	397	4,998	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0	234	5	290	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
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: 150011		Period: From 07/01/2014 To 06/30/2015		Worksheet S-3 Part II Date/Time Prepared: 11/23/2015 7:14 am	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	49,321,742	-199,915	49,121,827	1,925,129.00	25.52	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		37,698	0	37,698	251.00	150.19	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)		6,774,511	1,006,936	7,781,447	404,473.00	19.24	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		556,368	0	556,368	7,622.00	73.00	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		207,900	0	207,900	1,242.00	167.39	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		13,557,706	0	13,557,706			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		3,818,820	0	3,818,820			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		1,770	0	1,770			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
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	842,833	99,070	941,903	28,929.00	32.56	26.00
27.00	Administrative & General	5.00	11,184,579	-2,781,394	8,403,185	311,634.00	26.96	27.00
28.00	Administrative & General under contract (see inst.)		3,356,462	0	3,356,462	16,097.00	208.51	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	477,447	19,145	496,592	29,137.00	17.04	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,503,768	0	1,503,768	106,160.00	14.17	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,277,677	0	1,277,677	62,581.00	20.42	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,210,152	-399,475	810,677	21,117.00	38.39	38.00
39.00	Central Services and Supply	14.00	131,444	32,761	164,205	8,959.00	18.33	39.00
40.00	Pharmacy	15.00	2,265,096	86,810	2,351,906	55,917.00	42.06	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part II
Date/Time Prepared:
11/23/2015 7:14 am

	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	0	0	0	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part III
Date/Time Prepared:
11/23/2015 7:14 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	55,459,649	-199,915	55,259,734	2,109,967.00	26.19	1.00
2.00	Excluded area salaries (see instructions)	6,774,511	1,006,936	7,781,447	404,473.00	19.24	2.00
3.00	Subtotal salaries (line 1 minus line 2)	48,685,138	-1,206,851	47,478,287	1,705,494.00	27.84	3.00
4.00	Subtotal other wages & related costs (see inst.)	764,268	0	764,268	8,864.00	86.22	4.00
5.00	Subtotal wage-related costs (see inst.)	13,559,476	0	13,559,476	0.00	28.56	5.00
6.00	Total (sum of lines 3 thru 5)	63,008,882	-1,206,851	61,802,031	1,714,358.00	36.05	6.00
7.00	Total overhead cost (see instructions)	22,249,458	-2,943,083	19,306,375	640,531.00	30.14	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part IV
Date/Time Prepared:
11/23/2015 7:14 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,057,333	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	2,204,914	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	131,237	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	8,381,208	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	994	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	40,149	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	489,561	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	516,036	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	4,121,467	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	30,213	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	311,451	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	17,284,563	24.00
Part B - Other than Core Related Cost			
25.00	EMPLOYEE RELATIONS	93,734	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet S-3 Part V Date/Time Prepared: 11/23/2015 7:14 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	Subprovider - IPF		0	0 3.00
4.00	Subprovider - IRF		0	0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other		0	0 18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet S-10 Date/Time Prepared: 11/23/2015 7:14 am
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				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.327504		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		12,384,750		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		52,082,458		6.00
7.00	Medicaid cost (line 1 times line 6)		17,057,213		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)		4,672,463		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		4,672,463		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	14,985,181	38,590,604	53,575,785	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	4,907,707	12,638,577	17,546,284	21.00
22.00	Partial payment by patients approved for charity care	156,640	12,979,889	13,136,529	22.00
23.00	Cost of charity care (line 21 minus line 22)	4,751,067	-341,312	4,409,755	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		12,819,675		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		672,739		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		12,146,936		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		3,978,170		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		8,387,925		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		13,060,388		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet A
Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)			
		1.00	2.00	3.00	4.00	5.00			
GENERAL SERVICE COST CENTERS									
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		12,658,568		12,658,568	-1,211,272	11,447,296	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	842,833	16,929,354	17,772,187	150,590	17,922,777	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	11,184,579	18,232,646	29,417,225	-2,568,278	26,848,947	5.00	
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00	
6.01	00601	CAFETERIA	0	0	0	1,366,143	1,366,143	6.01	
6.02	00602	CAFETERIA	0	0	0	0	0	6.02	
7.00	00700	OPERATION OF PLANT	477,447	4,242,839	4,720,286	444,542	5,164,828	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	432,419	432,419	0	432,419	8.00	
9.00	00900	HOUSEKEEPING	0	2,540,920	2,540,920	8,952	2,549,872	9.00	
10.00	01000	DIETARY	0	1,973,479	1,973,479	-1,418,570	554,909	10.00	
13.00	01300	NURSING ADMINISTRATION	1,210,152	43,425	1,253,577	-399,475	854,102	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	131,444	341,149	472,593	32,761	505,354	14.00	
15.00	01500	PHARMACY	2,265,096	6,406,521	8,671,617	-5,910,817	2,760,800	15.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	7,994,515	1,219,152	9,213,667	-397,069	8,816,598	30.00	
31.00	03100	INTENSIVE CARE UNIT	2,421,603	319,899	2,741,502	75,606	2,817,108	31.00	
40.00	04000	SUBPROVIDER - I/PF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - I/RF	1,009,050	814,836	1,823,886	38,829	1,862,715	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00	
43.00	04300	NURSERY	0	0	0	1,053,485	1,053,485	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,613,778	7,499,208	9,112,986	232,032	9,345,018	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,903,323	2,779,640	5,682,963	-755,260	4,927,703	54.00	
57.00	05700	CT SCAN	0	0	0	873,289	873,289	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	514,940	514,940	58.00	
59.00	05900	CARDIAC CATHETERIZATION	533,278	1,768,690	2,301,968	91,290	2,393,258	59.00	
60.00	06000	LABORATORY	2,430,770	4,267,892	6,698,662	112,540	6,811,202	60.00	
60.01	06001	ONCOLOGY	945,312	547,470	1,492,782	76,872	1,569,654	60.01	
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02	
65.00	06500	RESPIRATORY THERAPY	1,198,798	683,776	1,882,574	158,304	2,040,878	65.00	
66.00	06600	PHYSICAL THERAPY	1,568,067	285,599	1,853,666	76,491	1,930,157	66.00	
69.00	06900	ELECTROCARDIOLOGY	631,840	101,269	733,109	130,705	863,814	69.00	
69.01	06901	CARDIAC REHAB	98,665	5,324	103,989	39,190	143,179	69.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,002,249	6,002,249	73.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	211,240	91,402	302,642	82,780	385,422	90.00	
91.00	09100	EMERGENCY	3,884,491	981,443	4,865,934	143,524	5,009,458	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	864,194	144,082	1,008,276	117,191	1,125,467	95.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	44,420,475	85,311,002	129,731,477	-838,436	128,893,041	118.00	
NONREIMBURSABLE COST CENTERS									
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,456	14,456	20,886	35,342	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00	
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02	
192.03	19203	GREAT BEGINNINGS/MATERNAL	135,275	2,693	137,968	11,844	149,812	192.03	
192.04	19204	LIFELINE	0	0	0	0	0	192.04	
192.05	19205	OWNED PROPERTIES	0	1,070,829	1,070,829	-738,610	332,219	192.05	
192.08	19211	PARI SH NURSING	28,186	19,194	47,380	17,899	65,279	192.08	
192.09	19212	BIOTERRORISM GRANT	0	-10,927	-10,927	16,492	5,565	192.09	
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10	
192.14	19210	MGH PHYS PRACT MGMT	878,582	418,257	1,296,839	169,195	1,466,034	192.14	
192.15	19215	MGH MARION SURGEONS	379,695	1,824,411	2,204,106	104,245	2,308,351	192.15	
192.16	19216	MGH MGH MED ONC	0	1,015,163	1,015,163	0	1,015,163	192.16	
192.17	19217	MGH FMC SOUTH	584,728	1,704,507	2,289,235	472,845	2,762,080	192.17	
192.18	19218	MGH FAIRM MED ASSOC	58,811	250,543	309,354	4,484	313,838	192.18	
192.19	19219	MGH FMC MARION	185,452	539,761	725,213	46,191	771,404	192.19	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00	
193.01	19301	MGH FMC NORTHWOOD	244,263	608,517	852,780	23,123	875,903	193.01	
193.02	19302	MGH FMC GAS CITY	145,106	527,211	672,317	18,818	691,135	193.02	
193.03	19303	MGH HOSPITALISTS	0	2,678,358	2,678,358	64,046	2,742,404	193.03	
193.04	19304	MGH MAR FAM PRACT	678,644	1,470,663	2,149,307	49,522	2,198,829	193.04	
193.05	19305	MGH FMC SWAYZEE	62,640	115,951	178,591	32,983	211,574	193.05	
193.06	19306	MGH PEDIATRIC CTR	230,684	994,042	1,224,726	83,195	1,307,921	193.06	
193.07	19307	MGH SPECIALTY PHYS	71,759	260,148	331,907	46,452	378,359	193.07	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet A

Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
193.08	19308	MGH FMC CONVERSE	102,684	178,569	281,253	12,327	293,580	193.08
193.09	19309	MGH UPLAND HEALTH	331,830	962,072	1,293,902	33,917	1,327,819	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	48,369	205,095	253,464	12,953	266,417	193.11
193.12	19312	OB/GYN	394,461	1,921,684	2,316,145	41,112	2,357,257	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	206,721	206,721	194.03
194.04	07953	MGH WORK SOLUTIONS	297,812	480,849	778,661	81,261	859,922	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	42,286	100,320	142,606	6,535	149,141	194.05
194.08	07957	MGH SMMP BLDG	0	274,017	274,017	0	274,017	194.08
194.09	07958	MGH AMBUCARE BLDG	0	62,490	62,490	0	62,490	194.09
194.10	07959	MGH 106 LYONS BLDG	0	6,014	6,014	0	6,014	194.10
200.00		TOTAL (SUM OF LINES 118-199)	49,321,742	103,005,889	152,327,631	0	152,327,631	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet A
Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-207,516	11,239,780	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,858,243	25,781,020	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,564,303	20,284,644	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
6.01	00601	CAFETERIA	-23,896	1,342,247	6.01
6.02	00602	CAFETERIA	0	0	6.02
7.00	00700	OPERATION OF PLANT	-168,011	4,996,817	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-6,867	425,552	8.00
9.00	00900	HOUSEKEEPING	-2,333	2,547,539	9.00
10.00	01000	DIETARY	-5,698	549,211	10.00
13.00	01300	NURSING ADMINISTRATION	-61	854,041	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-625	504,729	14.00
15.00	01500	PHARMACY	-32,493	2,728,307	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-27,721	8,788,877	30.00
31.00	03100	INTENSIVE CARE UNIT	-616	2,816,492	31.00
40.00	04000	SUBPROVIDER - I PF	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	-77,027	1,785,688	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	1,053,485	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-25,477	9,319,541	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-167,986	4,759,717	54.00
57.00	05700	CT SCAN	0	873,289	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	514,940	58.00
59.00	05900	CARDIAC CATHETERIZATION	-7,355	2,385,903	59.00
60.00	06000	LABORATORY	-72,536	6,738,666	60.00
60.01	06001	ONCOLOGY	-9,352	1,560,302	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	-14,289	2,026,589	65.00
66.00	06600	PHYSICAL THERAPY	-98	1,930,059	66.00
69.00	06900	ELECTROCARDIOLOGY	-53,740	810,074	69.00
69.01	06901	CARDIAC REHAB	-10	143,169	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,400	5,999,849	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-237	385,185	90.00
91.00	09100	EMERGENCY	-166,584	4,842,874	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-74,648	1,050,819	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	146,364	129,039,405	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	35,342	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	149,812	192.03
192.04	19204	LIFELINE	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	332,219	192.05
192.08	19211	PARI SH NURSING	0	65,279	192.08
192.09	19212	BIOTERRORISM GRANT	0	5,565	192.09
192.10	19214	BREAST PUMPS	0	0	192.10
192.14	19210	MGH PHYS PRACT MGMT	-63,467	1,402,567	192.14
192.15	19215	MGH MARION SURGEONS	-76,658	2,231,693	192.15
192.16	19216	MGH MGH MED ONC	0	1,015,163	192.16
192.17	19217	MGH FMC SOUTH	-320,299	2,441,781	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	313,838	192.18
192.19	19219	MGH FMC MARION	-59,975	711,429	192.19
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	875,903	193.01
193.02	19302	MGH FMC GAS CITY	0	691,135	193.02
193.03	19303	MGH HOSPITALISTS	0	2,742,404	193.03
193.04	19304	MGH MAR FAM PRACT	0	2,198,829	193.04
193.05	19305	MGH FMC SWAYZEE	-28,735	182,839	193.05
193.06	19306	MGH PEDIATRIC CTR	-80,622	1,227,299	193.06
193.07	19307	MGH SPECIALTY PHYS	-42,145	336,214	193.07
193.08	19308	MGH FMC CONVERSE	0	293,580	193.08
193.09	19309	MGH UPLAND HEALTH	0	1,327,819	193.09

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet A
Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
193.10	19310	MGH MGH WOMENS CTR	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	-9,521	256,896	193.11
193.12	19312	OB/GYN	0	2,357,257	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	194.00
194.01	07950	MOW	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	194.02
194.03	07952	ADVERTISING	0	206,721	194.03
194.04	07953	MGH WORK SOLUTIONS	-103,522	756,400	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	149,141	194.05
194.08	07957	MGH SMMP BLDG	0	274,017	194.08
194.09	07958	MGH AMBUCARE BLDG	0	62,490	194.09
194.10	07959	MGH 106 LYONS BLDG	0	6,014	194.10
200.00		TOTAL (SUM OF LINES 118-199)	-638,580	151,689,051	200.00

RECLASSIFICATIONS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6
Date/Time Prepared:
11/23/2015 7:14 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - SATELLITE OFFICE RECLASS						
1.00	ELECTROCARDIOLOGY	69.00	9,263	4,042	1.00	
2.00	RADIOLOGY-DIAGNOSTIC	54.00	96,270	25,556	2.00	
	TOTALS		105,533	29,598		
B - CAFETERIA RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	81,124	1.00	
2.00	CAFETERIA	6.01	0	1,366,143	2.00	
	TOTALS		0	1,447,267		
C - ADMIN DIRECTOR RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	44,372	0	1.00	
2.00	CENTRAL SERVICES & SUPPLY	14.00	24,129	0	2.00	
3.00	ADULTS & PEDIATRICS	30.00	231,794	0	3.00	
4.00	OPERATING ROOM	50.00	45,164	0	4.00	
5.00	CARDIAC CATHETERIZATION	59.00	62,825	0	5.00	
6.00	RESPIRATORY THERAPY	65.00	103,234	0	6.00	
7.00	ELECTROCARDIOLOGY	69.00	65,049	0	7.00	
8.00	CARDIAC REHAB	69.01	18,848	0	8.00	
9.00	CLINIC	90.00	34,411	0	9.00	
11.00	AMBULANCE SERVICES	95.00	48,250	0	11.00	
12.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	190.00	20,886	0	12.00	
13.00	GREAT BEGGININGS/MATERNAL	192.03	6,990	0	13.00	
14.00	PARI SH NURSING	192.08	11,757	0	14.00	
15.00	BIOTERRORISM GRANT	192.09	16,492	0	15.00	
	TOTALS		734,201	0		
D - ADVERTISING						
1.00	ADVERTISING	194.03	165,532	41,189	1.00	
	TOTALS		165,532	41,189		
E - LEASED PROPERTY						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40,209	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	117,207	2.00	
3.00	OPERATION OF PLANT	7.00	0	425,397	3.00	
4.00	HOUSEKEEPING	9.00	0	8,952	4.00	
5.00	DIETARY	10.00	0	28,697	5.00	
6.00	OPERATING ROOM	50.00	0	187,213	6.00	
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	293,297	7.00	
8.00	CT SCAN	57.00	0	20,484	8.00	
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	23,055	9.00	
10.00	LABORATORY	60.00	0	68,212	10.00	
11.00	ELECTROCARDIOLOGY	69.00	0	17,183	11.00	
12.00	CARDIAC REHAB	69.01	0	15,535	12.00	
13.00	CLINIC	90.00	0	33,910	13.00	
15.00	PARI SH NURSING	192.08	0	4,095	15.00	
16.00	MGH PHYS PRACT MGMT	192.14	0	46,842	16.00	
17.00	MGH MARION SURGEONS	192.15	0	79,847	17.00	
18.00	MGH FMC SOUTH	192.17	0	335,854	18.00	
19.00	MGH FAIRM MED ASSOC	192.18	0	154	19.00	
20.00	MGH FMC MARION	192.19	0	32,458	20.00	
21.00	MGH WORK SOLUTIONS	194.04	0	9,009	21.00	
22.00	MGH FMC NORTHWOOD	193.01	0	1,239	22.00	
23.00	MGH FMC GAS CITY	193.02	0	2,385	23.00	
24.00	MGH FMC SWAYZEE	193.05	0	24,768	24.00	
25.00	MGH PEDIATRIC CTR	193.06	0	65,961	25.00	
26.00	MGH SPECIALTY PHYS	193.07	0	40,896	26.00	
27.00	MGH FMC CONVERSE	193.08	0	154	27.00	
28.00	MGH UPLAND HEALTH	193.09	0	6,345	28.00	
29.00	MGH MGH PSYCHIATRY	193.11	0	14,132	29.00	
30.00	OB/GYN	193.12	0	6,392	30.00	
	TOTALS		0	1,949,882		
F - PHARMACY RECLASS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,002,249	1.00	
	TOTALS		0	6,002,249		
G - CT/MRI RECLASS						
1.00	CT SCAN	57.00	448,053	404,752	1.00	
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	258,425	233,460	2.00	
	TOTALS		706,478	638,212		
H - SHORT TERM DISABILITY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	11,311	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	55,974	2.00	
4.00	PHARMACY	15.00	0	4,622	4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	48,490	5.00	
6.00	INTENSIVE CARE UNIT	31.00	0	13,414	6.00	

RECLASSIFICATIONS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6

Date/Time Prepared:
11/23/2015 7:14 am

						Increases			
Cost Center		Line #	Salary	Other					
2.00		3.00	4.00	5.00					
8.00	OPERATING ROOM	50.00	0	6,541				8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,275				9.00	
10.00	CARDIAC CATHETERIZATION	59.00	0	1,724				10.00	
11.00	LABORATORY	60.00	0	6,453				11.00	
12.00	ONCOLOGY	60.01	0	2,413				12.00	
13.00	RESPIRATORY THERAPY	65.00	0	4,218				13.00	
14.00	PHYSICAL THERAPY	66.00	0	7,784				14.00	
15.00	ELECTROCARDIOLOGY	69.00	0	2,667				15.00	
16.00	CLINIC	90.00	0	12				16.00	
17.00	EMERGENCY	91.00	0	8,607				17.00	
18.00	AMBULANCE SERVICES	95.00	0	1,074				18.00	
19.00	MGH PHYS PRACT MGMT	192.14	0	1,038				19.00	
20.00	MGH MARION SURGEONS	192.15	0	106				20.00	
21.00	MGH FMC SOUTH	192.17	0	3,377				21.00	
22.00	MGH FMC MARION	192.19	0	1,536				22.00	
23.00	MGH FMC GAS CITY	193.02	0	1,901				23.00	
24.00	MGH MAR FAM PRACT	193.04	0	1,855				24.00	
26.00	MGH PEDIATRIC CTR	193.06	0	2,268				26.00	
27.00	MGH SPECIALTY PHYS	193.07	0	566				27.00	
28.00	MGH UPLAND HEALTH	193.09	0	323				28.00	
29.00	MGH MGH PSYCHIATRY	193.11	0	236				29.00	
30.00	OB/GYN	193.12	0	130				30.00	
TOTALS			0	199,915					
I - NURSERY RECLASS									
1.00	NURSERY	43.00	876,659	176,826				1.00	
TOTALS			876,659	176,826					
J - MANAGEMENT BONUS									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	41,752	0				1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	601,774	0				2.00	
3.00	NURSING ADMINISTRATION	13.00	155,125	0				3.00	
4.00	PHARMACY	15.00	24,963	0				4.00	
5.00	ADULTS & PEDIATRICS	30.00	83,590	0				5.00	
6.00	INTENSIVE CARE UNIT	31.00	37,240	0				6.00	
7.00	RADIOLOGY-DIAGNOSTIC	54.00	48,890	0				7.00	
8.00	LABORATORY	60.00	50,416	0				8.00	
9.00	ONCOLOGY	60.01	30,508	0				9.00	
10.00	PHYSICAL THERAPY	66.00	23,163	0				10.00	
11.00	CLINIC	90.00	10,965	0				11.00	
12.00	EMERGENCY	91.00	34,720	0				12.00	
13.00	AMBULANCE SERVICES	95.00	8,450	0				13.00	
14.00	MGH PHYS PRACT MGMT	192.14	76,693	0				14.00	
15.00	MGH FMC SOUTH	192.17	88,610	0				15.00	
16.00	MGH HOSPITALISTS	193.03	64,046	0				16.00	
17.00	MGH WORK SOLUTIONS	194.04	51,212	0				17.00	
TOTALS			1,432,117	0					
K - GAINSHARE BONUS									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	12,064	0				1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	159,871	0				2.00	
3.00	OPERATION OF PLANT	7.00	17,742	0				3.00	
4.00	NURSING ADMINISTRATION	13.00	10,067	0				4.00	
5.00	CENTRAL SERVICES & SUPPLY	14.00	4,296	0				5.00	
6.00	PHARMACY	15.00	33,647	0				6.00	
7.00	ADULTS & PEDIATRICS	30.00	171,558	0				7.00	
8.00	INTENSIVE CARE UNIT	31.00	41,843	0				8.00	
9.00	SUBPROVIDER - IRF	41.00	19,310	0				9.00	
10.00	RADIOLOGY-DIAGNOSTIC	54.00	62,399	0				10.00	
11.00	CARDIAC CATHETERIZATION	59.00	14,162	0				11.00	
12.00	LABORATORY	60.00	64,794	0				12.00	
13.00	ONCOLOGY	60.01	22,509	0				13.00	
14.00	RESPIRATORY THERAPY	65.00	27,950	0				14.00	
15.00	PHYSICAL THERAPY	66.00	27,089	0				15.00	
16.00	ELECTROCARDIOLOGY	69.00	16,911	0				16.00	
17.00	CARDIAC REHAB	69.01	2,392	0				17.00	
18.00	CLINIC	90.00	1,739	0				18.00	
19.00	EMERGENCY	91.00	77,871	0				19.00	
20.00	AMBULANCE SERVICES	95.00	29,878	0				20.00	
21.00	GREAT BEGINNINGS/MATERNAL	192.03	2,416	0				21.00	
22.00	PARISH NURSING	192.08	1,020	0				22.00	
23.00	MGH PHYS PRACT MGMT	192.14	23,270	0				23.00	
24.00	MGH MARION SURGEONS	192.15	12,147	0				24.00	
25.00	MGH FMC SOUTH	192.17	24,676	0				25.00	
26.00	MGH FAIRM MED ASSOC	192.18	2,749	0				26.00	
27.00	MGH FMC MARION	192.19	6,500	0				27.00	
28.00	MGH FMC NORTHWOOD	193.01	10,893	0				28.00	

RECLASSIFICATIONS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6

Date/Time Prepared:
11/23/2015 7:14 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
29.00	MGH FMC GAS CITY	193.02	8,185	0	29.00
30.00	MGH MAR FAM PRACT	193.04	24,448	0	30.00
31.00	MGH FMC SWAYZEE	193.05	4,092	0	31.00
32.00	MGH PEDIATRIC CTR	193.06	8,578	0	32.00
33.00	MGH SPECIALTY PHYS	193.07	2,759	0	33.00
34.00	MGH FMC CONVERSE	193.08	5,464	0	34.00
35.00	MGH UPLAND HEALTH	193.09	13,723	0	35.00
36.00	OB/GYN	193.12	17,263	0	36.00
37.00	MGH WORK SOLUTIONS	194.04	10,472	0	37.00
38.00	MGH TAYLOR UNIVERSITY	194.05	3,253	0	38.00
	TOTALS		1,000,000	0	
L - COMMITMENT RECOGNITION BONUS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	12,193	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	161,587	0	2.00
3.00	OPERATION OF PLANT	7.00	17,895	0	3.00
4.00	NURSING ADMINISTRATION	13.00	10,637	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	4,336	0	5.00
6.00	PHARMACY	15.00	32,822	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	169,474	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	40,895	0	8.00
9.00	SUBPROVIDER - IRF	41.00	19,519	0	9.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	63,018	0	11.00
12.00	CARDIAC CATHETERIZATION	59.00	14,303	0	12.00
13.00	LABORATORY	60.00	64,249	0	13.00
14.00	ONCOLOGY	60.01	23,855	0	14.00
15.00	RESPIRATORY THERAPY	65.00	27,120	0	15.00
16.00	PHYSICAL THERAPY	66.00	26,239	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	18,257	0	17.00
18.00	CARDIAC REHAB	69.01	2,415	0	18.00
19.00	CLINIC	90.00	1,755	0	19.00
20.00	EMERGENCY	91.00	79,183	0	20.00
21.00	AMBULANCE SERVICES	95.00	30,613	0	21.00
22.00	GREAT BEGINNINGS/MATERNAL	192.03	2,438	0	22.00
23.00	PARI SH NURSING	192.08	1,027	0	23.00
24.00	MGH PHYS PRACT MGMT	192.14	22,390	0	24.00
25.00	MGH MARION SURGEONS	192.15	12,251	0	25.00
26.00	MGH FMC SOUTH	192.17	23,705	0	26.00
27.00	MGH FAIRM MED ASSOC	192.18	1,581	0	27.00
28.00	MGH FMC MARION	192.19	7,233	0	28.00
29.00	MGH FMC NORTHWOOD	193.01	10,991	0	29.00
30.00	MGH FMC GAS CITY	193.02	8,248	0	30.00
31.00	MGH MAR FAM PRACT	193.04	25,074	0	31.00
32.00	MGH FMC SWAYZEE	193.05	4,123	0	32.00
33.00	MGH PEDIATRIC CTR	193.06	8,656	0	33.00
34.00	MGH SPECIALTY PHYS	193.07	2,797	0	34.00
35.00	MGH FMC CONVERSE	193.08	6,709	0	35.00
36.00	MGH UPLAND HEALTH	193.09	13,849	0	36.00
38.00	OB/GYN	193.12	17,457	0	38.00
39.00	MGH WORK SOLUTIONS	194.04	10,568	0	39.00
40.00	MGH TAYLOR UNIVERSITY	194.05	3,282	0	40.00
	TOTALS		1,002,744	0	
500.00	Grand Total: Increases		6,023,264	10,485,138	500.00

RECLASSIFICATIONS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6
Date/Time Prepared:
11/23/2015 7:14 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - SATELLITE OFFICE RECLASS							
1.00	LABORATORY	60.00	9,263	4,042	0		1.00
2.00	LABORATORY	60.00	96,270	25,556	0		2.00
	TOTALS		105,533	29,598			
B - CAFETERIA RECLASS							
1.00	DIETARY	10.00	0	81,124	0		1.00
2.00	DIETARY	10.00	0	1,366,143	0		2.00
	TOTALS		0	1,447,267			
C - ADMIN DIRECTOR RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	49,783	0	0		1.00
2.00	OPERATION OF PLANT	7.00	16,492	0	0		2.00
3.00	NURSING ADMINISTRATION	13.00	575,304	0	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	44,372	0	0		4.00
5.00	EMERGENCY	91.00	48,250	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
	TOTALS		734,201	0			
D - ADVERTISING							
1.00	ADMINISTRATIVE & GENERAL	5.00	165,532	41,189	0		1.00
	TOTALS		165,532	41,189			
E - LEASED PROPERTY							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,211,272	9		1.00
2.00	OWNED PROPERTIES	192.05	0	738,610	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
	TOTALS		0	1,949,882			
F - PHARMACY RECLASS							
1.00	PHARMACY	15.00	0	6,002,249	0		1.00
	TOTALS		0	6,002,249			
G - CT/MRI RECLASS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	706,478	638,212	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		706,478	638,212			
H - SHORT TERM DISABILITY RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	11,311	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	55,974	0	0		2.00
4.00	PHARMACY	15.00	4,622	0	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	48,490	0	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	13,414	0	0		6.00
8.00	OPERATING ROOM	50.00	6,541	0	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	11,275	0	0		9.00

RECLASSIFICATIONS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6

Date/Time Prepared:
11/23/2015 7:14 am

Decreases							
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
10.00	CARDIAC CATHETERIZATION	59.00	1,724	0	0	10.00	
11.00	LABORATORY	60.00	6,453	0	0	11.00	
12.00	ONCOLOGY	60.01	2,413	0	0	12.00	
13.00	RESPIRATORY THERAPY	65.00	4,218	0	0	13.00	
14.00	PHYSICAL THERAPY	66.00	7,784	0	0	14.00	
15.00	ELECTROCARDIOLOGY	69.00	2,667	0	0	15.00	
16.00	CLINIC	90.00	12	0	0	16.00	
17.00	EMERGENCY	91.00	8,607	0	0	17.00	
18.00	AMBULANCE SERVICES	95.00	1,074	0	0	18.00	
19.00	MGH PHYS PRACT MGMT	192.14	1,038	0	0	19.00	
20.00	MGH MARION SURGEONS	192.15	106	0	0	20.00	
21.00	MGH FMC SOUTH	192.17	3,377	0	0	21.00	
22.00	MGH FMC MARION	192.19	1,536	0	0	22.00	
23.00	MGH FMC GAS CITY	193.02	1,901	0	0	23.00	
24.00	MGH MAR FAM PRACT	193.04	1,855	0	0	24.00	
26.00	MGH PEDIATRIC CTR	193.06	2,268	0	0	26.00	
27.00	MGH SPECIALTY PHYS	193.07	566	0	0	27.00	
28.00	MGH UPLAND HEALTH	193.09	323	0	0	28.00	
29.00	MGH MGH PSYCHIATRY	193.11	236	0	0	29.00	
30.00	OB/GYN	193.12	130	0	0	30.00	
	TOTALS		199,915	0			
I - NURSERY RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	876,659	176,826	0	1.00	
	TOTALS		876,659	176,826			
J - MANAGEMENT BONUS							
1.00	ADMINISTRATIVE & GENERAL	5.00	1,432,117	0	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
4.00		0.00	0	0	0	4.00	
5.00		0.00	0	0	0	5.00	
6.00		0.00	0	0	0	6.00	
7.00		0.00	0	0	0	7.00	
8.00		0.00	0	0	0	8.00	
9.00		0.00	0	0	0	9.00	
10.00		0.00	0	0	0	10.00	
11.00		0.00	0	0	0	11.00	
12.00		0.00	0	0	0	12.00	
13.00		0.00	0	0	0	13.00	
14.00		0.00	0	0	0	14.00	
15.00		0.00	0	0	0	15.00	
16.00		0.00	0	0	0	16.00	
17.00		0.00	0	0	0	17.00	
	TOTALS		1,432,117	0			
K - GAINSHARE BONUS							
1.00	ADMINISTRATIVE & GENERAL	5.00	1,000,000	0	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
4.00		0.00	0	0	0	4.00	
5.00		0.00	0	0	0	5.00	
6.00		0.00	0	0	0	6.00	
7.00		0.00	0	0	0	7.00	
8.00		0.00	0	0	0	8.00	
9.00		0.00	0	0	0	9.00	
10.00		0.00	0	0	0	10.00	
11.00		0.00	0	0	0	11.00	
12.00		0.00	0	0	0	12.00	
13.00		0.00	0	0	0	13.00	
14.00		0.00	0	0	0	14.00	
15.00		0.00	0	0	0	15.00	
16.00		0.00	0	0	0	16.00	
17.00		0.00	0	0	0	17.00	
18.00		0.00	0	0	0	18.00	
19.00		0.00	0	0	0	19.00	
20.00		0.00	0	0	0	20.00	
21.00		0.00	0	0	0	21.00	
22.00		0.00	0	0	0	22.00	
23.00		0.00	0	0	0	23.00	
24.00		0.00	0	0	0	24.00	
25.00		0.00	0	0	0	25.00	
26.00		0.00	0	0	0	26.00	
27.00		0.00	0	0	0	27.00	
28.00		0.00	0	0	0	28.00	
29.00		0.00	0	0	0	29.00	
30.00		0.00	0	0	0	30.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-7
Part I
Date/Time Prepared:
11/23/2015 7:14 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	4,422,248	0	0	0	1.00
2.00	Land Improvements	3,262,659	79,097	0	79,097	2.00
3.00	Buildings and Fixtures	108,317,369	8,428,916	0	8,428,916	3.00
4.00	Building Improvements	859,249	12,077	0	12,077	4.00
5.00	Fixed Equipment	1,098,638	100,320	0	100,320	5.00
6.00	Movable Equipment	74,920,817	4,551,767	0	4,551,767	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	192,880,980	13,172,177	0	13,172,177	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	192,880,980	13,172,177	0	13,172,177	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	4,422,248	0			1.00
2.00	Land Improvements	3,341,756	0			2.00
3.00	Buildings and Fixtures	108,209,879	0			3.00
4.00	Building Improvements	871,326	0			4.00
5.00	Fixed Equipment	1,005,608	0			5.00
6.00	Movable Equipment	77,858,280	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	195,709,097	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	195,709,097	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-7
Part II
Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	12,658,568	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	12,658,568	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	12,658,568				
3.00	Total (sum of lines 1-2)	0	12,658,568				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-7
Part III
Date/Time Prepared:
11/23/2015 7:14 am

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	NEW CAP REL COSTS-BLDG & FIXT	192,902,639	0	192,902,639	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	192,902,639	0	192,902,639	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	11,448,085	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	11,448,085	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	-208,305	0	0	0	11,239,780	1.00
3.00	Total (sum of lines 1-2)	-208,305	0	0	0	11,239,780	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-8

Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst. A-7	Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00		0	7.00
8.00 Television and radio service (chapter 21)			0		0.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-401,661	0				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0				0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-21,137	0	CAFETERIA	6.01		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients			0		0.00		0	17.00
18.00 Sale of medical records and abstracts			0		0.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines			0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00		0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00			0		0.00		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	3.00	
33.01	RETURNED CHECK FEE	B	-660	ADMINISTRATIVE & GENERAL	5.00	0 33.01
33.02	PHYSICIAN PRIVILEGE	B	-3,100	ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.03	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-74,656	ADMINISTRATIVE & GENERAL	5.00	0 33.03
33.04	CHILD SEAT SAFETY INSPECTION	B	-488	ADMINISTRATIVE & GENERAL	5.00	0 33.04
33.05	HEALTH SCREENING FEES - LAB	B	-18,058	LABORATORY	60.00	0 33.05
33.06	HEALTH SCREENING FEES - RADIOLOGY	B	-11,859	RADIOLOGY-DIAGNOSTIC	54.00	0 33.06
33.07	MED STAFF OTHER SCREENING-MED STAFF	B	1,003	ADMINISTRATIVE & GENERAL	5.00	0 33.07
33.08	HEALTH SCREENING FEES	B	-1,988	LABORATORY	60.00	0 33.08
33.09	FLU SHOT HEALTH SCREENS	B	-10	ADMINISTRATIVE & GENERAL	5.00	0 33.09
33.10	REBATE	B	-60,740	ADMINISTRATIVE & GENERAL	5.00	0 33.10
33.11	RENTAL OF PROVIDER SPACE BY SUPPLIER	B	-1,200	ADMINISTRATIVE & GENERAL	5.00	0 33.11
33.12	RENT SPACE UPLAND	B	-14,589	LABORATORY	60.00	0 33.12
33.13	PAGER RENTAL	B	-3,200	ADMINISTRATIVE & GENERAL	5.00	0 33.13
33.14	SALE OF SCRAP, WASTE, ETC,	B	-14,938	ADMINISTRATIVE & GENERAL	5.00	0 33.14
33.15	SALE OF XRAY FILM	B	-68	RADIOLOGY-DIAGNOSTIC	54.00	0 33.15
33.16	EMPL UNIFORMS	B	-93	ADMINISTRATIVE & GENERAL	5.00	0 33.16
33.17	PCC MARKETING AG	B	-956	ADMINISTRATIVE & GENERAL	5.00	0 33.17
33.18	EDUCATIONAL WORKSHOP	B	-2,635	ADMINISTRATIVE & GENERAL	5.00	0 33.18
33.19	OPT HEALTH LINEN SERV	B	-2,259	LAUNDRY & LINEN SERVICE	8.00	0 33.19
33.20	AMBULANCE SVC - ASSISTANTS	B	-72,125	AMBULANCE SERVICES	95.00	0 33.20
33.21	AMBULANCE SVC - CORONER SVC	B	-744	AMBULANCE SERVICES	95.00	0 33.21
33.22	AMBULANCE SVC - LINEN SERVICES	B	-4,608	LAUNDRY & LINEN SERVICE	8.00	0 33.22
33.23	AMBULANCE SVC - COMMUNITY EVENT STAFF	B	-1,309	AMBULANCE SERVICES	95.00	0 33.23
33.24	AMBULANCE SVC - OTHER EVENT	B	-250	AMBULANCE SERVICES	95.00	0 33.24
33.25	CONTRACT ARU OTHER ARU MEDICAL DIRECTOR	B	-63,377	SUBPROVIDER - IRF	41.00	0 33.25
33.26	SCHOOL PHYS OTHER SCHOOL PHYS	B	-6,000	ADMINISTRATIVE & GENERAL	5.00	0 33.26
33.27	PHLEBOTOMY	B	-5,130	LABORATORY	60.00	0 33.27
33.28	PRECEPT OTHER PHARMACY STUDENT	B	-2,400	DRUGS CHARGED TO PATIENTS	73.00	0 33.28
33.29	CLINICAL STUDY- OTHER	B	-8,309	ONCOLOGY	60.01	0 33.29
33.30	SICK CHILD CARE PROGRAM	B	-587	ADULTS & PEDIATRICS	30.00	0 33.30
33.31	UNCLINICAL MED OTHER 125 MED/CHILD CARE	B	-20,693	ADMINISTRATIVE & GENERAL	5.00	0 33.31
33.32	VENDING MACHINES	B	-2,759	CAFETERIA	6.01	0 33.32
33.33	CPR TRAIN OTHER AHA COMMUNITY	B	-5,149	ADMINISTRATIVE & GENERAL	5.00	0 33.33
33.34	PHYSICIAN RECRUITMENT	A	-964,037	ADMINISTRATIVE & GENERAL	5.00	0 33.34
33.35	ED ANESTHESIOLOGIST	A	-1,300,079	ADMINISTRATIVE & GENERAL	5.00	0 33.35
33.36	GAIN ON DISPOSAL	A	-14,205	ADMINISTRATIVE & GENERAL	5.00	0 33.36
33.37	TELEVISION AND RADIO SERVICE	A	-16,872	OPERATION OF PLANT	7.00	0 33.37
33.38	TELEPHONE SERVICE	A	-9,792	ADMINISTRATIVE & GENERAL	5.00	0 33.38
33.39	TELEPHONE SERVICE	A	-146,548	OPERATION OF PLANT	7.00	0 33.39
33.40	MISC REV	B	-2,630	ADMINISTRATIVE & GENERAL	5.00	0 33.40
33.41	MISC REV	B	-25	OPERATION OF PLANT	7.00	0 33.41
33.42	ENTERTAINMENT EXP	A	-562	ADMINISTRATIVE & GENERAL	5.00	0 33.42
33.43	EMPLOYEE USE OF AUTO	A	-4,724	ADMINISTRATIVE & GENERAL	5.00	0 33.43
33.44	DONATIONS	A	-266,534	ADMINISTRATIVE & GENERAL	5.00	0 33.44
33.45	VHA OPPORTUNITY	A	-1,425	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.45
33.46	VHA OPPORTUNITY	A	-22,282	ADMINISTRATIVE & GENERAL	5.00	0 33.46
33.47	VHA OPPORTUNITY	A	-4,566	OPERATION OF PLANT	7.00	0 33.47
33.48	VHA OPPORTUNITY	A	-2,333	HOUSEKEEPING	9.00	0 33.48
33.49	VHA OPPORTUNITY	A	-5,698	DIETARY	10.00	0 33.49
33.50	VHA OPPORTUNITY	A	-625	CENTRAL SERVICES & SUPPLY	14.00	0 33.50
33.51	VHA OPPORTUNITY	A	-32,076	PHARMACY	15.00	0 33.51
33.52	VHA OPPORTUNITY	A	-27,134	ADULTS & PEDIATRICS	30.00	0 33.52
33.53	VHA OPPORTUNITY	A	-616	INTENSIVE CARE UNIT	31.00	0 33.53
33.54	VHA OPPORTUNITY	A	-250	SUBPROVIDER - IRF	41.00	0 33.54
33.55	VHA OPPORTUNITY	A	-25,477	OPERATING ROOM	50.00	0 33.55
33.56	VHA OPPORTUNITY	A	-6,059	RADIOLOGY-DIAGNOSTIC	54.00	0 33.56
33.57	VHA OPPORTUNITY	A	-7,355	CARDIAC CATHETERIZATION	59.00	0 33.57
33.58	VHA OPPORTUNITY	A	-23,771	LABORATORY	60.00	0 33.58
33.59	VHA OPPORTUNITY	A	-400	ONCOLOGY	60.01	0 33.59
33.60	VHA OPPORTUNITY	A	-3,683	RESPIRATORY THERAPY	65.00	0 33.60
33.61	VHA OPPORTUNITY	A	-98	PHYSICAL THERAPY	66.00	0 33.61
33.62	VHA OPPORTUNITY	A	-10	CARDIAC REHAB	69.01	0 33.62
33.63	VHA OPPORTUNITY	A	-85	ELECTROCARDIOLOGY	69.00	0 33.63

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-8
Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.64 VHA OPPORTUNITY	A	-237	CLINIC		90.00	0 33.64
33.65 VHA OPPORTUNITY	A	-1,584	EMERGENCY		91.00	0 33.65
33.66 VHA OPPORTUNITY	A	-220	AMBULANCE SERVICES		95.00	0 33.66
33.67 FINANCE BANK SERVICE CHARGES	A	-276,593	ADMINISTRATIVE & GENERAL		5.00	0 33.67
33.68 FINANCE DISCOUNT PAYMENTS	A	4,936	ADMINISTRATIVE & GENERAL		5.00	0 33.68
33.69 NONALLOWABLE 2008 BONDS	A	-161,936	NEW CAP REL COSTS-BLDG & FIXT		1.00	11 33.69
33.70 BLDG COSTS	A	789	NEW CAP REL COSTS-BLDG & FIXT		1.00	9 33.70
33.71 ELIMINATING ENTRIES	A	-63,467	MGH PHYS PRACT MGMT		192.14	0 33.71
33.72 ELIMINATING ENTRIES	A	-103,522	MGH WORK SOLUTIONS		194.04	0 33.72
33.73 ELIMINATING ENTRIES	A	-76,658	MGH MARION SURGEONS		192.15	0 33.73
33.74 ELIMINATING ENTRIES	A	-59,975	MGH FMC MARION		192.19	0 33.74
33.75 ELIMINATING ENTRIES	A	-28,735	MGH FMC SWAYZEE		193.05	0 33.75
33.76 ELIMINATING ENTRIES	A	-80,622	MGH PEDIATRIC CTR		193.06	0 33.76
33.77 ELIMINATING ENTRIES	A	-9,521	MGH MGH PSYCHIATRY		193.11	0 33.77
33.78 ELIMINATING ENTRIES	A	-42,145	MGH SPECIALTY PHYS		193.07	0 33.78
33.79 ELIMINATING ENTRIES	A	-320,299	MGH FMC SOUTH		192.17	0 33.79
33.80		0			0.00	0 33.80
33.81 LOBBYING COSTS	A	-17,268	ADMINISTRATIVE & GENERAL		5.00	0 33.81
33.82 LOBBYING COSTS	A	-61	NURSING ADMINISTRATION		13.00	0 33.82
33.83 LOBBYING COSTS	A	-417	PHARMACY		15.00	0 33.83
33.84 LOBBYING COSTS	A	-643	ONCOLOGY		60.01	0 33.84
33.85 OPERATING INTEREST INCOME	B	-46,369	NEW CAP REL COSTS-BLDG & FIXT		1.00	11 33.85
33.86 ED ON CALL SVC A/C 7000.2512	A	-2,147,784	ADMINISTRATIVE & GENERAL		5.00	0 33.86
33.87 XIX ASSESSMENT FEE A/C 7200.7892	A	-1,349,234	ADMINISTRATIVE & GENERAL		5.00	0 33.87
33.88 SELF INSURANCE EXPENSE	A	-1,316,494	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.88
33.89 PENSION ADJUSTMENT	A	9,176,162	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.89
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-638,580				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-8-2

Date/Time Prepared:
11/23/2015 7:14 am

	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	41.00	SUBPROVIDER - IRF	13,400	13,400	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	53,655	53,655	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	10,606	10,606	0	0	0	3.00
4.00	91.00	EMERGENCY	165,000	165,000	0	0	0	4.00
5.00	60.00	LABORATORY	9,000	9,000	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	150,000	150,000	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			401,661	401,661	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	41.00	SUBPROVIDER - IRF	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	41.00	SUBPROVIDER - IRF	0	0	0	13,400	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	53,655	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	10,606	3.00
4.00	91.00	EMERGENCY	0	0	0	165,000	4.00
5.00	60.00	LABORATORY	0	0	0	9,000	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	150,000	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	401,661	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part I
Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADM NI STRATI VE & GENERAL	
		NEW BLDG & FIXT				
	0	1.00	4.00	4A	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	11,239,780	11,239,780			1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	25,781,020	424,779	26,205,799		4.00
5.00 00500	ADM NI STRATI VE & GENERAL	20,284,644	1,855,009	4,570,637	26,710,290	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
6.01 00601	CAFETERIA	1,342,247	147,949	0	1,490,196	6.01
6.02 00602	CAFETERIA	0	0	0	0	6.02
7.00 00700	OPERATI ON OF PLANT	4,996,817	2,835,283	270,104	8,102,204	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	425,552	64,594	0	490,146	8.00
9.00 00900	HOUSEKEEPING	2,547,539	103,338	0	2,650,877	9.00
10.00 01000	DI ETARY	549,211	207,348	0	756,559	10.00
13.00 01300	NURSI NG ADM NI STRATI ON	854,041	21,389	440,939	1,316,369	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	504,729	72,844	89,314	666,887	14.00
15.00 01500	PHARMACY	2,728,307	93,346	1,279,237	4,100,890	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	8,788,877	1,336,853	4,202,169	14,327,899	30.00
31.00 03100	INTENSIVE CARE UNIT	2,816,492	305,858	1,350,973	4,473,323	31.00
40.00 04000	SUBPROVIDER - I PF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I RF	1,785,688	289,939	569,957	2,645,584	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	1,053,485	0	476,828	1,530,313	43.00
ANCI LLARY SERVICE COST CENTERS						
50.00 05000	OPERATI NG ROOM	9,319,541	1,069,525	898,578	11,287,644	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
54.00 05400	RADI OLOGY-DI AGNOSTIC	4,759,717	633,288	1,335,935	6,728,940	54.00
57.00 05700	CT SCAN	873,289	46,475	243,703	1,163,467	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	514,940	135,788	140,561	791,289	58.00
59.00 05900	CARDI AC CATHETERI ZATI ON	2,385,903	153,998	338,774	2,878,675	59.00
60.00 06000	LABORATORY	6,738,666	387,471	1,358,832	8,484,969	60.00
60.01 06001	ONCOLOGY	1,560,302	0	554,669	2,114,971	60.01
60.02 06002	RADI ATI ON ONCOLOGY	0	0	0	0	60.02
65.00 06500	RESPI RATORY THERAPY	2,026,589	140,340	735,854	2,902,783	65.00
66.00 06600	PHYSI CAL THERAPY	1,930,059	26,919	890,266	2,847,244	66.00
69.00 06900	ELECTROCARDI OLOGY	810,074	244,045	401,764	1,455,883	69.00
69.01 06901	CARDI AC REHAB	143,169	39,630	66,532	249,331	69.01
71.00 07100	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATI ENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATI ENTS	5,999,849	0	0	5,999,849	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLI NIC	385,185	86,532	141,471	613,188	90.00
91.00 09100	EMERGENCY	4,842,874	338,736	2,186,216	7,367,826	91.00
92.00 09200	OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0	0	0	92.00
92.01 09201	OBSERVATI ON BEDS (DI STI NCT PART)	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVI CES	1,050,819	126,896	533,206	1,710,921	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	129,039,405	11,188,172	23,076,519	125,858,517	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35,342	41,158	11,360	87,860	190.00
192.00 19200	PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	192.00
192.02 19202	VISI TOR MEALS	0	0	0	0	192.02
192.03 19203	GREAT BEGI NNI NGS/MATERNAL	149,812	0	80,020	229,832	192.03
192.04 19204	LI FELI NE	0	0	0	0	192.04
192.05 19205	OWNED PROPRTI ES	332,219	0	0	332,219	192.05
192.08 19211	PARI SH NURSI NG	65,279	10,450	22,839	98,568	192.08
192.09 19212	BI OTERRORI SM GRANT	5,565	0	8,970	14,535	192.09
192.10 19214	BREAST PUMPS	0	0	0	0	192.10
192.14 19210	MGH PHYS PRACT MGMT	1,402,567	0	543,859	1,946,426	192.14
192.15 19215	MGH MAR ION SURGEONS	2,231,693	0	219,735	2,451,428	192.15
192.16 19216	MGH MGH MED ONC	1,015,163	0	0	1,015,163	192.16
192.17 19217	MGH FMC SOUTH	2,441,781	0	390,717	2,832,498	192.17
192.18 19218	MGH FAI RM MED ASSOC	313,838	0	34,343	348,181	192.18
192.19 19219	MGH FMC MAR ION	711,429	0	107,504	818,933	192.19
193.00 19300	NONPAI D WORKERS	0	0	0	0	193.00
193.01 19301	MGH FMC NORTHWOOD	875,903	0	144,761	1,020,664	193.01
193.02 19302	MGH FMC GAS CI TY	691,135	0	86,830	777,965	193.02
193.03 19303	MGH HOSPI TALI STS	2,742,404	0	34,836	2,777,240	193.03
193.04 19304	MGH MAR FAM PRACT	2,198,829	0	395,051	2,593,880	193.04

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part I
Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
193.05 19305 MGH FMC SWAYZEE	182,839	0		38,539	221,378	47,313	193.05
193.06 19306 MGH PEDIATRIC CTR	1,227,299	0		133,613	1,360,912	290,853	193.06
193.07 19307 MGH SPECIALTY PHYS	336,214	0		41,745	377,959	80,777	193.07
193.08 19308 MGH FMC CONVERSE	293,580	0		62,472	356,052	76,095	193.08
193.09 19309 MGH UPLAND HEALTH	1,327,819	0		195,308	1,523,127	325,521	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0		0	0	0	193.10
193.11 19311 MGH MGH PSYCHIATRY	256,896	0		25,539	282,435	60,362	193.11
193.12 19312 OB/GYN	2,357,257	0		233,367	2,590,624	553,666	193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0	0	0	193.15
194.00 07963 OTHER NONREIMBURSABLE	0	0		0	0	0	194.00
194.01 07950 MOW	0	0		0	0	0	194.01
194.02 07951 MENTAL HEALTH	0	0		0	0	0	194.02
194.03 07952 ADVERTISING	206,721	0		90,035	296,756	63,422	194.03
194.04 07953 MGH WORK SOLUTIONS	756,400	0		201,283	957,683	204,675	194.04
194.05 07954 MGH TAYLOR UNIVERSITY	149,141	0		26,554	175,695	37,549	194.05
194.08 07957 MGH SMMP BLDG	274,017	0		0	274,017	58,563	194.08
194.09 07958 MGH AMBUCARE BLDG	62,490	0		0	62,490	13,355	194.09
194.10 07959 MGH 106 LYONS BLDG	6,014	0		0	6,014	1,285	194.10
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers				0		201.00
202.00	TOTAL (sum lines 118-201)	151,689,051	11,239,780	26,205,799	151,689,051	26,710,290	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet B Part I Date/Time Prepared: 11/23/2015 7:14 am			
Cost Center Description		MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		6.00	6.01	6.02	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
6.01	00601	CAFETERIA	0	1,808,679			6.01
6.02	00602	CAFETERIA	0	1,711,907	1,711,907		6.02
7.00	00700	OPERATION OF PLANT	0	0	37,934	9,871,733	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	106,689	701,589
9.00	00900	HOUSEKEEPING	0	0	0	170,682	15,363
10.00	01000	DIETARY	0	0	0	342,474	7,804
13.00	01300	NURSING ADMINISTRATION	0	0	28,055	35,327	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	11,890	120,315	7,950
15.00	01500	PHARMACY	0	0	73,448	154,179	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	387,216	2,208,062	209,069
31.00	03100	INTENSIVE CARE UNIT	0	0	108,361	505,182	43,854
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	53,721	478,888	23,297
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	43,575	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	84,984	1,766,521	123,248
51.00	05100	RECOVERY ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	121,096	1,045,993	57,475
57.00	05700	CT SCAN	0	0	22,889	76,761	14,539
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	13,201	224,278	62
59.00	05900	CARDIAC CATHETERIZATION	0	0	30,093	254,357	9,345
60.00	06000	LABORATORY	0	0	136,072	639,981	553
60.01	06001	ONCOLOGY	0	0	0	0	6,759
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	56,086	231,798	7,711
66.00	06600	PHYSICAL THERAPY	0	0	32,876	44,462	18,387
69.00	06900	ELECTROCARDIOLOGY	0	0	39,071	403,085	5,508
69.01	06901	CARDIAC REHAB	0	0	6,211	65,457	66
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	10,537	142,925	5,018
91.00	09100	EMERGENCY	0	0	200,193	559,485	117,127
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	66,003	209,592	24,827
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,711,907	1,563,512	9,786,493	697,962
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	947	67,980	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.02	19202	VISITOR MEALS	0	96,772	0	0	0
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0
192.04	19204	LIFELINE	0	0	0	0	0
192.05	19205	OWNED PROPERTIES	0	0	0	0	0
192.08	19211	PARISH NURSING	0	0	2,317	17,260	0
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0
192.10	19214	BREAST PUMPS	0	0	0	0	0
192.14	19210	MGH PHYS PRACT MGMT	0	0	62,340	0	0
192.15	19215	MGH MARION SURGEONS	0	0	28,458	0	0
192.16	19216	MGH MGH MED ONC	0	0	0	0	0
192.17	19217	MGH FMC SOUTH	0	0	0	0	614
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	8
192.19	19219	MGH FMC MARION	0	0	17,416	0	216
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0
193.02	19302	MGH FMC GAS CITY	0	0	0	0	268
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0
193.04	19304	MGH MAR FAM PRACT	0	0	0	0	529
193.05	19305	MGH FMC SWAYZEE	0	0	0	0	0
193.06	19306	MGH PEDIATRIC CTR	0	0	21,433	0	440
193.07	19307	MGH SPECIALTY PHYS	0	0	5,744	0	90
193.08	19308	MGH FMC CONVERSE	0	0	0	0	56
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	1,096

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
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Cost Center Description			MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			6.00	6.01	6.02	7.00	8.00	
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	2,775	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	6,965	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	0	310	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
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)	0	1,808,679	1,711,907	9,871,733	701,589	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

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Part I
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Cost Center Description		HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
6.01	00601 CAFETERIA						6.01
6.02	00602 CAFETERIA						6.02
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING	3,403,465					9.00
10.00	01000 DIETARY	48,927	1,317,455				10.00
13.00	01300 NURSING ADMINISTRATION	15,290	0	1,676,374			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	76,448	0	0	1,026,016		14.00
15.00	01500 PHARMACY	48,927	0	76,777	0	5,330,659	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	709,435	784,502	404,768	297,547	0	30.00
31.00	03100 INTENSIVE CARE UNIT	195,707	136,706	113,273	102,602	0	31.00
40.00	04000 SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00	04100 SUBPROVIDER - I/RF	171,244	131,808	56,156	20,520	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	0	45,551	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	501,499	0	88,837	174,423	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	152,896	0	134,100	20,520	0	54.00
57.00	05700 CT SCAN	9,174	0	23,927	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	13,799	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	61,158	0	31,458	20,520	0	59.00
60.00	06000 LABORATORY	171,244	0	157,991	51,301	0	60.00
60.01	06001 ONCOLOGY	0	0	53,642	2,565	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	128,433	0	64,648	56,431	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66,498	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	82,564	0	41,583	4,104	0	69.00
69.01	06901 CARDIAC REHAB	91,738	0	6,493	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	5,330,659	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	61,158	0	11,015	0	0	90.00
91.00	09100 EMERGENCY	684,974	14,552	209,269	112,862	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	21,405	0	68,995	10,260	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,232,221	1,067,568	1,668,780	873,655	5,330,659	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,116	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202 VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203 GREAT BEGINNINGS/MATERNAL	0	0	0	0	0	192.03
192.04	19204 LIFELINE	0	0	0	0	0	192.04
192.05	19205 OWNED PROPERTIES	12,232	0	0	0	0	192.05
192.08	19211 PARISH NURSING	6,116	0	7,594	0	0	192.08
192.09	19212 BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214 BREAST PUMPS	0	0	0	0	0	192.10
192.14	19210 MGH PHYS PRACT MGMT	24,463	0	0	0	0	192.14
192.15	19215 MGH MARION SURGEONS	0	0	0	29,241	0	192.15
192.16	19216 MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217 MGH FMC SOUTH	122,317	0	0	20,520	0	192.17
192.18	19218 MGH FAIRM MED ASSOC	0	0	0	0	0	192.18
192.19	19219 MGH FMC MARION	0	0	0	20,520	0	192.19
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301 MGH FMC NORTHWOOD	0	0	0	2,565	0	193.01
193.02	19302 MGH FMC GAS CITY	0	0	0	10,260	0	193.02
193.03	19303 MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304 MGH MAR FAM PRACT	0	0	0	30,780	0	193.04
193.05	19305 MGH FMC SWAYZEE	0	0	0	2,565	0	193.05
193.06	19306 MGH PEDIATRIC CTR	0	0	0	2,565	0	193.06
193.07	19307 MGH SPECIALTY PHYS	0	0	0	0	0	193.07
193.08	19308 MGH FMC CONVERSE	0	0	0	2,565	0	193.08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

Period:
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Cost Center Description		HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY		
		9.00	10.00	13.00	14.00	15.00		
193.09	19309	MGH UPLAND HEALTH	0	0	0	20,520	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	150,719	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	99,168	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	10,260	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
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)	3,403,465	1,317,455	1,676,374	1,026,016	5,330,659	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

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To 06/30/2015

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
6.01	00601	CAFETERIA			6.01
6.02	00602	CAFETERIA			6.02
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
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	22,390,597	0	22,390,597
31.00	03100	INTENSIVE CARE UNIT	6,635,042	0	6,635,042
40.00	04000	SUBPROVIDER - IPF	0	0	0
41.00	04100	SUBPROVIDER - IRF	4,146,630	0	4,146,630
42.00	04200	SUBPROVIDER	0	0	0
43.00	04300	NURSERY	1,946,496	0	1,946,496
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	16,439,540	0	16,439,540
51.00	05100	RECOVERY ROOM	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,699,122	0	9,699,122
57.00	05700	CT SCAN	1,559,412	0	1,559,412
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,211,742	0	1,211,742
59.00	05900	CARDIAC CATHETERIZATION	3,900,834	0	3,900,834
60.00	06000	LABORATORY	11,455,510	0	11,455,510
60.01	06001	ONCOLOGY	2,629,946	0	2,629,946
60.02	06002	RADIATION ONCOLOGY	0	0	0
65.00	06500	RESPIRATORY THERAPY	4,068,270	0	4,068,270
66.00	06600	PHYSICAL THERAPY	3,617,977	0	3,617,977
69.00	06900	ELECTROCARDIOLOGY	2,342,948	0	2,342,948
69.01	06901	CARDIAC REHAB	472,583	0	472,583
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	12,612,790	0	12,612,790
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	974,891	0	974,891
91.00	09100	EMERGENCY	10,840,932	0	10,840,932
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,477,659	0	2,477,659
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			
118.00		SUBTOTALS (SUM OF LINES 1-117)	119,422,921	0	119,422,921
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	181,680	0	181,680
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0
192.02	19202	VISITOR MEALS	96,772	0	96,772
192.03	19203	GREAT BEGINNINGS/MATERNAL	278,951	0	278,951
192.04	19204	LIFELINE	0	0	0
192.05	19205	OWNED PROPERTIES	415,453	0	415,453
192.08	19211	PARI SH NURSING	152,921	0	152,921
192.09	19212	BIOTERRORISM GRANT	17,641	0	17,641
192.10	19214	BREAST PUMPS	0	0	0
192.14	19210	MGH PHYS PRACT MGMT	2,449,217	0	2,449,217
192.15	19215	MGH MARION SURGEONS	3,033,044	0	3,033,044
192.16	19216	MGH MGH MED ONC	1,232,123	0	1,232,123
192.17	19217	MGH FMC SOUTH	3,581,308	0	3,581,308
192.18	19218	MGH FAIRM MED ASSOC	422,602	0	422,602
192.19	19219	MGH FMC MARION	1,032,107	0	1,032,107
193.00	19300	NONPAID WORKERS	0	0	0
193.01	19301	MGH FMC NORTHWOOD	1,241,364	0	1,241,364
193.02	19302	MGH FMC GAS CITY	954,759	0	954,759
193.03	19303	MGH HOSPITALISTS	3,370,789	0	3,370,789
193.04	19304	MGH MAR FAM PRACT	3,179,550	0	3,179,550
193.05	19305	MGH FMC SWAYZEE	271,256	0	271,256
193.06	19306	MGH PEDIATRIC CTR	1,676,203	0	1,676,203

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

Period:
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To 06/30/2015

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
193.07	19307	MGH SPECIALTY PHYS	464,570	0	464,570	193.07
193.08	19308	MGH FMC CONVERSE	434,768	0	434,768	193.08
193.09	19309	MGH UPLAND HEALTH	1,870,264	0	1,870,264	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	345,572	0	345,572	193.11
193.12	19312	OB/GYN	3,144,290	0	3,144,290	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	194.00
194.01	07950	MOW	150,719	0	150,719	194.01
194.02	07951	MENTAL HEALTH	99,168	0	99,168	194.02
194.03	07952	ADVERTISING	367,143	0	367,143	194.03
194.04	07953	MGH WORK SOLUTIONS	1,172,928	0	1,172,928	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	213,244	0	213,244	194.05
194.08	07957	MGH SMMP BLDG	332,580	0	332,580	194.08
194.09	07958	MGH AMBUCARE BLDG	75,845	0	75,845	194.09
194.10	07959	MGH 106 LYONS BLDG	7,299	0	7,299	194.10
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	151,689,051	0	151,689,051	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

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Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	424,779	424,779	424,779		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	1,855,009	1,855,009	74,067	1,929,076	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01 00601	CAFETERIA	0	147,949	147,949	0	23,001	6.01
6.02 00602	CAFETERIA	0	0	0	0	0	6.02
7.00 00700	OPERATION OF PLANT	0	2,835,283	2,835,283	4,378	125,058	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	64,594	64,594	0	7,565	8.00
9.00 00900	HOUSEKEEPING	0	103,338	103,338	0	40,916	9.00
10.00 01000	DIETARY	0	207,348	207,348	0	11,677	10.00
13.00 01300	NURSING ADMINISTRATION	0	21,389	21,389	7,148	20,318	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	72,844	72,844	1,448	10,293	14.00
15.00 01500	PHARMACY	0	93,346	93,346	20,737	63,297	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	1,336,853	1,336,853	68,118	221,182	30.00
31.00 03100	INTENSIVE CARE UNIT	0	305,858	305,858	21,900	69,046	31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	289,939	289,939	9,239	40,835	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	7,730	23,620	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	1,069,525	1,069,525	14,566	174,225	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	633,288	633,288	21,656	103,861	54.00
57.00 05700	CT SCAN	0	46,475	46,475	3,950	17,958	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	135,788	135,788	2,279	12,214	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	153,998	153,998	5,492	44,432	59.00
60.00 06000	LABORATORY	0	387,471	387,471	22,027	130,965	60.00
60.01 06001	ONCOLOGY	0	0	0	8,991	32,645	60.01
60.02 06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00 06500	RESPIRATORY THERAPY	0	140,340	140,340	11,928	44,804	65.00
66.00 06600	PHYSICAL THERAPY	0	26,919	26,919	14,431	43,947	66.00
69.00 06900	ELECTROCARDIOLOGY	0	244,045	244,045	6,513	22,472	69.00
69.01 06901	CARDIAC REHAB	0	39,630	39,630	1,078	3,848	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	92,608	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	86,532	86,532	2,293	9,465	90.00
91.00 09100	EMERGENCY	0	338,736	338,736	35,439	113,722	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	126,896	126,896	8,643	26,408	95.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	11,188,172	11,188,172	374,051	1,530,382	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	41,158	41,158	184	1,356	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02 19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03 19203	GREAT BEGINNINGS/MATERNAL	0	0	0	1,297	3,547	192.03
192.04 19204	LIFELINE	0	0	0	0	0	192.04
192.05 19205	OWNED PROPERTIES	0	0	0	0	5,128	192.05
192.08 19211	PARI SH NURSING	0	10,450	10,450	370	1,521	192.08
192.09 19212	BIOTERRORISM GRANT	0	0	0	145	224	192.09
192.10 19214	BREAST PUMPS	0	0	0	0	0	192.10
192.14 19210	MGH PHYS PRACT MGMT	0	0	0	8,816	30,043	192.14
192.15 19215	MGH MARION SURGEONS	0	0	0	3,562	37,838	192.15
192.16 19216	MGH MGH MED ONC	0	0	0	0	15,669	192.16
192.17 19217	MGH FMC SOUTH	0	0	0	6,334	43,720	192.17
192.18 19218	MGH FAIRM MED ASSOC	0	0	0	557	5,374	192.18
192.19 19219	MGH FMC MARION	0	0	0	1,743	12,640	192.19
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301	MGH FMC NORTHWOOD	0	0	0	2,347	15,754	193.01
193.02 19302	MGH FMC GAS CITY	0	0	0	1,408	12,008	193.02
193.03 19303	MGH HOSPITALISTS	0	0	0	565	42,867	193.03
193.04 19304	MGH MAR FAM PRACT	0	0	0	6,404	40,037	193.04
193.05 19305	MGH FMC SWAYZEE	0	0	0	625	3,417	193.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
193.06 19306 MGH PEDIATRIC CTR	0	0	0	0	2,166	21,006	193.06
193.07 19307 MGH SPECIALTY PHYS	0	0	0	0	677	5,834	193.07
193.08 19308 MGH FMC CONVERSE	0	0	0	0	1,013	5,496	193.08
193.09 19309 MGH UPLAND HEALTH	0	0	0	0	3,166	23,509	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	0	193.10
193.11 19311 MGH MGH PSYCHIATRY	0	0	0	0	414	4,359	193.11
193.12 19312 OB/GYN	0	0	0	0	3,783	39,986	193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	0	193.15
194.00 07963 OTHER NONREIMBURSABLE	0	0	0	0	0	0	194.00
194.01 07950 MOW	0	0	0	0	0	0	194.01
194.02 07951 MENTAL HEALTH	0	0	0	0	0	0	194.02
194.03 07952 ADVERTISING	0	0	0	0	1,459	4,580	194.03
194.04 07953 MGH WORK SOLUTIONS	0	0	0	0	3,263	14,782	194.04
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	0	0	430	2,712	194.05
194.08 07957 MGH SMMP BLDG	0	0	0	0	0	4,229	194.08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	0	0	965	194.09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0	93	194.10
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	11,239,780		11,239,780	424,779	1,929,076	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet B Part II Date/Time Prepared: 11/23/2015 7:14 am			
Cost Center Description		MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		6.00	6.01	6.02	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
6.01	00601	CAFETERIA	0	170,950			6.01
6.02	00602	CAFETERIA	0	161,803	161,803		6.02
7.00	00700	OPERATION OF PLANT	0	0	3,585	2,968,304	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	32,080	104,239
9.00	00900	HOUSEKEEPING	0	0	0	51,322	2,283
10.00	01000	DIETARY	0	0	0	102,977	1,160
13.00	01300	NURSING ADMINISTRATION	0	0	2,652	10,622	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,124	36,177	1,181
15.00	01500	PHARMACY	0	0	6,942	46,360	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	36,599	663,935	31,063
31.00	03100	INTENSIVE CARE UNIT	0	0	10,242	151,902	6,516
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	5,077	143,995	3,461
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	4,119	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	8,032	531,170	18,312
51.00	05100	RECOVERY ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	11,446	314,517	8,539
57.00	05700	CT SCAN	0	0	2,163	23,081	2,160
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,248	67,438	9
59.00	05900	CARDIAC CATHETERIZATION	0	0	2,844	76,482	1,388
60.00	06000	LABORATORY	0	0	12,861	192,434	82
60.01	06001	ONCOLOGY	0	0	0	0	1,004
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	5,301	69,699	1,146
66.00	06600	PHYSICAL THERAPY	0	0	3,107	13,369	2,732
69.00	06900	ELECTROCARDIOLOGY	0	0	3,693	121,203	818
69.01	06901	CARDIAC REHAB	0	0	587	19,682	10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	996	42,976	746
91.00	09100	EMERGENCY	0	0	18,922	168,230	17,402
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	6,238	63,022	3,689
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	161,803	147,778	2,942,673	103,701
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	89	20,441	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.02	19202	VISITOR MEALS	0	9,147	0	0	0
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0
192.04	19204	LIFELINE	0	0	0	0	0
192.05	19205	OWNED PROPERTIES	0	0	0	0	0
192.08	19211	PARISH NURSING	0	0	219	5,190	0
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0
192.10	19214	BREAST PUMPS	0	0	0	0	0
192.14	19210	MGH PHYS PRACT MGMT	0	0	5,892	0	0
192.15	19215	MGH MARION SURGEONS	0	0	2,690	0	0
192.16	19216	MGH MGH MED ONC	0	0	0	0	0
192.17	19217	MGH FMC SOUTH	0	0	0	0	91
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	1
192.19	19219	MGH FMC MARION	0	0	1,646	0	32
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0
193.02	19302	MGH FMC GAS CITY	0	0	0	0	40
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0
193.04	19304	MGH MAR FAM PRACT	0	0	0	0	79
193.05	19305	MGH FMC SWAYZEE	0	0	0	0	0
193.06	19306	MGH PEDIATRIC CTR	0	0	2,026	0	65
193.07	19307	MGH SPECIALTY PHYS	0	0	543	0	13
193.08	19308	MGH FMC CONVERSE	0	0	0	0	8
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	163

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

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Cost Center Description			MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			6.00	6.01	6.02	7.00	8.00	
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	262	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	658	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	0	46	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
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)	0	170,950	161,803	2,968,304	104,239	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150011		Period: From 07/01/2014 To 06/30/2015		Worksheet B Part II Date/Time Prepared: 11/23/2015 7:14 am		
Cost Center Description		HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY		
		9.00	10.00	13.00	14.00	15.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
6.00	00600	MAINTENANCE & REPAIRS					6.00	
6.01	00601	CAFETERIA					6.01	
6.02	00602	CAFETERIA					6.02	
7.00	00700	OPERATION OF PLANT					7.00	
8.00	00800	LAUNDRY & LINEN SERVICE					8.00	
9.00	00900	HOUSEKEEPING	197,859				9.00	
10.00	01000	DIETARY	2,844	326,006			10.00	
13.00	01300	NURSING ADMINISTRATION	889	0	63,018		13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	4,444	0	0	127,511	14.00	
15.00	01500	PHARMACY	2,844	0	2,886	0	236,412	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,245	194,126	15,217	36,979	0	30.00
31.00	03100	INTENSIVE CARE UNIT	11,377	33,828	4,258	12,751	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	9,955	32,616	2,111	2,550	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	1,712	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,154	0	3,340	21,677	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,889	0	5,041	2,550	0	54.00
57.00	05700	CT SCAN	533	0	899	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	519	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,555	0	1,183	2,550	0	59.00
60.00	06000	LABORATORY	9,955	0	5,939	6,376	0	60.00
60.01	06001	ONCOLOGY	0	0	2,016	319	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	7,466	0	2,430	7,013	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,500	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	4,800	0	1,563	510	0	69.00
69.01	06901	CARDIAC REHAB	5,333	0	244	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	236,412	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,555	0	414	0	0	90.00
91.00	09100	EMERGENCY	39,821	3,601	7,867	14,026	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,244	0	2,594	1,275	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	187,903	264,171	62,733	108,576	236,412	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	356	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	711	0	0	0	0	192.05
192.08	19211	PARISH NURSING	356	0	285	0	0	192.08
192.09	19212	BIOETHICS GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.14	19210	MGH PHYS PRACT MGMT	1,422	0	0	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	0	0	3,634	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	7,111	0	0	2,550	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	0	192.18
192.19	19219	MGH FMC MARION	0	0	0	2,550	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	319	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	1,275	0	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	3,825	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	319	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	0	319	0	193.06
193.07	19307	MGH SPECIALTY PHYS	0	0	0	0	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	0	319	0	193.08

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY		
		9.00	10.00	13.00	14.00	15.00		
193.09	19309	MGH UPLAND HEALTH	0	0	0	2,550	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	37,296	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	24,539	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	1,275	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
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)	197,859	326,006	63,018	127,511	236,412	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet B Part II Date/Time Prepared: 11/23/2015 7:14 am
Cost Center	Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
		24.00	25.00	26.00
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500 ADMINISTRATIVE & GENERAL			5.00
6.00	00600 MAINTENANCE & REPAIRS			6.00
6.01	00601 CAFETERIA			6.01
6.02	00602 CAFETERIA			6.02
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
13.00	01300 NURSING ADMINISTRATION			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY			14.00
15.00	01500 PHARMACY			15.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	2,645,317	0	2,645,317
31.00	03100 INTENSIVE CARE UNIT	627,678	0	627,678
40.00	04000 SUBPROVIDER - IPF	0	0	0
41.00	04100 SUBPROVIDER - IRF	539,778	0	539,778
42.00	04200 SUBPROVIDER	0	0	0
43.00	04300 NURSERY	37,181	0	37,181
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	1,870,001	0	1,870,001
51.00	05100 RECOVERY ROOM	0	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,109,787	0	1,109,787
57.00	05700 CT SCAN	97,219	0	97,219
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	219,495	0	219,495
59.00	05900 CARDIAC CATHETERIZATION	291,924	0	291,924
60.00	06000 LABORATORY	768,110	0	768,110
60.01	06001 ONCOLOGY	44,975	0	44,975
60.02	06002 RADIATION ONCOLOGY	0	0	0
65.00	06500 RESPIRATORY THERAPY	290,127	0	290,127
66.00	06600 PHYSICAL THERAPY	107,005	0	107,005
69.00	06900 ELECTROCARDIOLOGY	405,617	0	405,617
69.01	06901 CARDIAC REHAB	70,412	0	70,412
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	329,020	0	329,020
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	146,977	0	146,977
91.00	09100 EMERGENCY	757,766	0	757,766
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	240,009	0	240,009
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,598,398	0	10,598,398
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	63,584	0	63,584
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0
192.02	19202 VISITOR MEALS	9,147	0	9,147
192.03	19203 GREAT BEGINNINGS/MATERNAL	4,844	0	4,844
192.04	19204 LIFELINE	0	0	0
192.05	19205 OWNED PROPERTIES	5,839	0	5,839
192.08	19211 PARISH NURSING	18,391	0	18,391
192.09	19212 BIOTERRORISM GRANT	369	0	369
192.10	19214 BREAST PUMPS	0	0	0
192.14	19210 MGH PHYS PRACT MGMT	46,173	0	46,173
192.15	19215 MGH MARION SURGEONS	47,724	0	47,724
192.16	19216 MGH MGH MED ONC	15,669	0	15,669
192.17	19217 MGH FMC SOUTH	59,806	0	59,806
192.18	19218 MGH FAIRM MED ASSOC	5,932	0	5,932
192.19	19219 MGH FMC MARION	18,611	0	18,611
193.00	19300 NONPAID WORKERS	0	0	0
193.01	19301 MGH FMC NORTHWOOD	18,420	0	18,420
193.02	19302 MGH FMC GAS CITY	14,731	0	14,731
193.03	19303 MGH HOSPITALISTS	43,432	0	43,432
193.04	19304 MGH MAR FAM PRACT	50,345	0	50,345
193.05	19305 MGH FMC SWAYZEE	4,361	0	4,361
193.06	19306 MGH PEDIATRIC CTR	25,582	0	25,582

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part II
Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
193.07	19307	MGH SPECIALTY PHYS	7,067	0	7,067	193.07
193.08	19308	MGH FMC CONVERSE	6,836	0	6,836	193.08
193.09	19309	MGH UPLAND HEALTH	29,388	0	29,388	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	5,035	0	5,035	193.11
193.12	19312	OB/GYN	43,769	0	43,769	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	194.00
194.01	07950	MOW	37,296	0	37,296	194.01
194.02	07951	MENTAL HEALTH	24,539	0	24,539	194.02
194.03	07952	ADVERTISING	6,697	0	6,697	194.03
194.04	07953	MGH WORK SOLUTIONS	19,366	0	19,366	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	3,142	0	3,142	194.05
194.08	07957	MGH SMMP BLDG	4,229	0	4,229	194.08
194.09	07958	MGH AMBUCARE BLDG	965	0	965	194.09
194.10	07959	MGH 106 LYONS BLDG	93	0	93	194.10
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,239,780	0	11,239,780	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1
Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5A	5.00	6.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	367,851					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	13,902	48,179,924				4.00
5.00 00500 ADMINISTRATIVE & GENERAL	60,710	8,403,185	-26,710,290	124,978,761		5.00
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	293,239	6.00
6.01 00601 CAFETERIA	4,842	0	0	1,490,196	4,842	6.01
6.02 00602 CAFETERIA	0	0	0	0	0	6.02
7.00 00700 OPERATION OF PLANT	92,792	496,592	0	8,102,204	92,792	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	2,114	0	0	490,146	2,114	8.00
9.00 00900 HOUSEKEEPING	3,382	0	0	2,650,877	3,382	9.00
10.00 01000 DIETARY	6,786	0	0	756,559	6,786	10.00
13.00 01300 NURSING ADMINISTRATION	700	810,677	0	1,316,369	700	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	2,384	164,205	0	666,887	2,384	14.00
15.00 01500 PHARMACY	3,055	2,351,906	0	4,100,890	3,055	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	43,752	7,725,782	0	14,327,899	43,752	30.00
31.00 03100 INTENSIVE CARE UNIT	10,010	2,483,795	0	4,473,323	10,010	31.00
40.00 04000 SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - I/RF	9,489	1,047,879	0	2,645,584	9,489	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	0	876,659	0	1,530,313	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	35,003	1,652,056	0	11,287,644	35,003	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	20,726	2,456,147	0	6,728,940	20,726	54.00
57.00 05700 CT SCAN	1,521	448,053	0	1,163,467	1,521	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	4,444	258,425	0	791,289	4,444	58.00
59.00 05900 CARDIAC CATHETERIZATION	5,040	622,844	0	2,878,675	5,040	59.00
60.00 06000 LABORATORY	12,681	2,498,243	0	8,484,969	12,681	60.00
60.01 06001 ONCOLOGY	0	1,019,771	0	2,114,971	0	60.01
60.02 06002 RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00 06500 RESPIRATORY THERAPY	4,593	1,352,884	0	2,902,783	4,593	65.00
66.00 06600 PHYSICAL THERAPY	881	1,636,774	0	2,847,244	881	66.00
69.00 06900 ELECTROCARDIOLOGY	7,987	738,653	0	1,455,883	7,987	69.00
69.01 06901 CARDIAC REHAB	1,297	122,320	0	249,331	1,297	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	5,999,849	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	2,832	260,098	0	613,188	2,832	90.00
91.00 09100 EMERGENCY	11,086	4,019,408	0	7,367,826	11,086	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	4,153	980,311	0	1,710,921	4,153	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	366,162	42,426,667	-26,710,290	99,148,227	291,550	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,347	20,886	0	87,860	1,347	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02 19202 VISITOR MEALS	0	0	0	0	0	192.02
192.03 19203 GREAT BEGINNINGS/MATERNAL	0	147,119	0	229,832	0	192.03
192.04 19204 LIFELINE	0	0	0	0	0	192.04
192.05 19205 OWNED PROPERTIES	0	0	0	332,219	0	192.05
192.08 19211 PARI SH NURSING	342	41,990	0	98,568	342	192.08
192.09 19212 BIOTERRORISM GRANT	0	16,492	0	14,535	0	192.09
192.10 19214 BREAST PUMPS	0	0	0	0	0	192.10
192.14 19210 MGH PHYS PRACT MGMT	0	999,897	0	1,946,426	0	192.14
192.15 19215 MGH MARION SURGEONS	0	403,987	0	2,451,428	0	192.15
192.16 19216 MGH MGH MED ONC	0	0	0	1,015,163	0	192.16
192.17 19217 MGH FMC SOUTH	0	718,342	0	2,832,498	0	192.17
192.18 19218 MGH FAIRM MED ASSOC	0	63,141	0	348,181	0	192.18
192.19 19219 MGH FMC MARION	0	197,649	0	818,933	0	192.19
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301 MGH FMC NORTHWOOD	0	266,147	0	1,020,664	0	193.01
193.02 19302 MGH FMC GAS CITY	0	159,638	0	777,965	0	193.02
193.03 19303 MGH HOSPITALISTS	0	64,046	0	2,777,240	0	193.03
193.04 19304 MGH MAR FAM PRACT	0	726,311	0	2,593,880	0	193.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1

Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00		4.00	5A	5.00	6.00	
193.05 19305 MGH FMC SWAYZEE	0		70,855	0	221,378	0	193.05
193.06 19306 MGH PEDIATRIC CTR	0		245,650	0	1,360,912	0	193.06
193.07 19307 MGH SPECIALTY PHYS	0		76,749	0	377,959	0	193.07
193.08 19308 MGH FMC CONVERSE	0		114,857	0	356,052	0	193.08
193.09 19309 MGH UPLAND HEALTH	0		359,079	0	1,523,127	0	193.09
193.10 19310 MGH MGH WOMENS CTR	0		0	0	0	0	193.10
193.11 19311 MGH MGH PSYCHIATRY	0		46,954	0	282,435	0	193.11
193.12 19312 OB/GYN	0		429,051	0	2,590,624	0	193.12
193.15 19315 MGH RIVER VIEW BLDG	0		0	0	0	0	193.15
194.00 07963 OTHER NONREIMBURSABLE	0		0	0	0	0	194.00
194.01 07950 MOW	0		0	0	0	0	194.01
194.02 07951 MENTAL HEALTH	0		0	0	0	0	194.02
194.03 07952 ADVERTISING	0		165,532	0	296,756	0	194.03
194.04 07953 MGH WORK SOLUTIONS	0		370,064	0	957,683	0	194.04
194.05 07954 MGH TAYLOR UNIVERSITY	0		48,821	0	175,695	0	194.05
194.08 07957 MGH SMMP BLDG	0		0	0	274,017	0	194.08
194.09 07958 MGH AMBUCARE BLDG	0		0	0	62,490	0	194.09
194.10 07959 MGH 106 LYONS BLDG	0		0	0	6,014	0	194.10
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)	11,239,780		26,205,799		26,710,290	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	30.555252		0.543915		0.213719	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			424,779		1,929,076	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.008817		0.015435	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1

Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description		CAFETERIA (MEALS SERVED)	CAFETERIA (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		6.01	6.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
6.01	00601	240,915					6.01
6.02	00602	228,025	1,316,638				6.02
7.00	00700		29,175	195,605			7.00
8.00	00800			2,114	703,632		8.00
9.00	00900			3,382	15,408	57,876	9.00
10.00	01000			6,786	7,827	832	10.00
13.00	01300		21,577	700		260	13.00
14.00	01400		9,145	2,384	7,973	1,300	14.00
15.00	01500		56,489	3,055		832	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000		297,810	43,752	209,677	12,064	30.00
31.00	03100		83,341	10,010	43,982	3,328	31.00
40.00	04000						40.00
41.00	04100		41,317	9,489	23,365	2,912	41.00
42.00	04200						42.00
43.00	04300		33,514				43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000		65,362	35,003	123,607	8,528	50.00
51.00	05100						51.00
54.00	05400		93,136	20,726	57,642	2,600	54.00
57.00	05700		17,604	1,521	14,581	156	57.00
58.00	05800		10,153	4,444	62		58.00
59.00	05900		23,145	5,040	9,372	1,040	59.00
60.00	06000		104,654	12,681	555	2,912	60.00
60.01	06001				6,779		60.01
60.02	06002						60.02
65.00	06500		43,136	4,593	7,733	2,184	65.00
66.00	06600		25,285	881	18,441		66.00
69.00	06900		30,050	7,987	5,524	1,404	69.00
69.01	06901		4,777	1,297	66	1,560	69.01
71.00	07100						71.00
72.00	07200						72.00
73.00	07300						73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000		8,104	2,832	5,033	1,040	90.00
91.00	09100		153,970	11,086	117,468	11,648	91.00
92.00	09200						92.00
92.01	09201						92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500		50,763	4,153	24,899	364	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		228,025	1,202,507	193,916	699,994	54,964	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000		728	1,347		104	190.00
192.00	19200						192.00
192.02	19202	12,890					192.02
192.03	19203						192.03
192.04	19204						192.04
192.05	19205					208	192.05
192.08	19211		1,782	342		104	192.08
192.09	19212						192.09
192.10	19214						192.10
192.14	19210		47,946			416	192.14
192.15	19215		21,887				192.15
192.16	19216						192.16
192.17	19217				616	2,080	192.17
192.18	19218					8	192.18
192.19	19219		13,395		217		192.19
193.00	19300						193.00
193.01	19301						193.01
193.02	19302				269		193.02
193.03	19303						193.03
193.04	19304				531		193.04
193.05	19305						193.05
193.06	19306		16,484		441		193.06
193.07	19307		4,418		90		193.07

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1

Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description			CAFETERIA A (MEALS SERVED)	CAFETERIA A (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			6.01	6.02	7.00	8.00	9.00	
193.08	19308	MGH FMC CONVERSE	0	0	0	56	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	1,099	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	2,134	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	5,357	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	311	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
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)	1,808,679	1,711,907	9,871,733	701,589	3,403,465	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.507540	1.300211	50.467693	0.997096	58.806155	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	170,950	161,803	2,968,304	104,239	197,859	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.709586	0.122891	15.174990	0.148144	3.418671	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1
Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description		DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)		
		10.00	13.00	14.00	15.00		
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
6.01	00601						6.01
6.02	00602						6.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	92,796					10.00
13.00	01300	0	1,233,395				13.00
14.00	01400	0	0	10,000			14.00
15.00	01500	0	56,489	0	1,000		15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	55,257	297,810	2,900	0		30.00
31.00	03100	9,629	83,341	1,000	0		31.00
40.00	04000	0	0	0	0		40.00
41.00	04100	9,284	41,317	200	0		41.00
42.00	04200	0	0	0	0		42.00
43.00	04300	0	33,514	0	0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	65,362	1,700	0		50.00
51.00	05100	0	0	0	0		51.00
54.00	05400	0	98,664	200	0		54.00
57.00	05700	0	17,604	0	0		57.00
58.00	05800	0	10,153	0	0		58.00
59.00	05900	0	23,145	200	0		59.00
60.00	06000	0	116,242	500	0		60.00
60.01	06001	0	39,467	25	0		60.01
60.02	06002	0	0	0	0		60.02
65.00	06500	0	47,565	550	0		65.00
66.00	06600	0	48,926	0	0		66.00
69.00	06900	0	30,595	40	0		69.00
69.01	06901	0	4,777	0	0		69.01
71.00	07100	0	0	0	0		71.00
72.00	07200	0	0	0	0		72.00
73.00	07300	0	0	0	1,000		73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	8,104	0	0		90.00
91.00	09100	1,025	153,970	1,100	0		91.00
92.00	09200						92.00
92.01	09201	0	0	0	0		92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	50,763	100	0		95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		75,195	1,227,808	8,515	1,000		118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0		190.00
192.00	19200	0	0	0	0		192.00
192.02	19202	0	0	0	0		192.02
192.03	19203	0	0	0	0		192.03
192.04	19204	0	0	0	0		192.04
192.05	19205	0	0	0	0		192.05
192.08	19211	0	5,587	0	0		192.08
192.09	19212	0	0	0	0		192.09
192.10	19214	0	0	0	0		192.10
192.14	19210	0	0	0	0		192.14
192.15	19215	0	0	285	0		192.15
192.16	19216	0	0	0	0		192.16
192.17	19217	0	0	200	0		192.17
192.18	19218	0	0	0	0		192.18
192.19	19219	0	0	200	0		192.19
193.00	19300	0	0	0	0		193.00
193.01	19301	0	0	25	0		193.01
193.02	19302	0	0	100	0		193.02
193.03	19303	0	0	0	0		193.03
193.04	19304	0	0	300	0		193.04
193.05	19305	0	0	25	0		193.05
193.06	19306	0	0	25	0		193.06

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1

Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description		DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)		
		10.00	13.00	14.00	15.00		
193.07	19307	MGH SPECIALTY PHYS	0	0	0		193.07
193.08	19308	MGH FMC CONVERSE	0	0	25	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	200	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07950	MOW	10,616	0	0	0	194.01
194.02	07951	MENTAL HEALTH	6,985	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	100	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	194.10
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)	1,317,455	1,676,374	1,026,016	5,330,659	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.197325	1.359154	102.601600	5,330.659000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	326,006	63,018	127,511	236,412	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.513147	0.051093	12.751100	236.412000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/23/2015 7:14 am
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		22,390,597	0	22,390,597	30.00
31.00	03100 INTENSIVE CARE UNIT		6,635,042	0	6,635,042	31.00
40.00	04000 SUBPROVIDER - I/PF		0	0	0	40.00
41.00	04100 SUBPROVIDER - I/RP		4,146,630	0	4,146,630	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
43.00	04300 NURSERY		1,946,496	0	1,946,496	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		16,439,540	0	16,439,540	50.00
51.00	05100 RECOVERY ROOM		0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		9,699,122	0	9,699,122	54.00
57.00	05700 CT SCAN		1,559,412	0	1,559,412	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,211,742	0	1,211,742	58.00
59.00	05900 CARDIAC CATHETERIZATION		3,900,834	0	3,900,834	59.00
60.00	06000 LABORATORY		11,455,510	0	11,455,510	60.00
60.01	06001 ONCOLOGY		2,629,946	0	2,629,946	60.01
60.02	06002 RADIATION ONCOLOGY		0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0	4,068,270	0	4,068,270	65.00
66.00	06600 PHYSICAL THERAPY	0	3,617,977	0	3,617,977	66.00
69.00	06900 ELECTROCARDIOLOGY		2,342,948	0	2,342,948	69.00
69.01	06901 CARDIAC REHAB		472,583	0	472,583	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		12,612,790	0	12,612,790	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		974,891	0	974,891	90.00
91.00	09100 EMERGENCY		10,840,932	0	10,840,932	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		4,146,556	0	4,146,556	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)		0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		2,477,659	0	2,477,659	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		123,569,477	0	123,569,477	200.00
201.00	Less Observation Beds		4,146,556	0	4,146,556	201.00
202.00	Total (see instructions)		119,422,921	0	119,422,921	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/23/2015 7:14 am
		Title XVII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,548,110		17,548,110	30.00
31.00	03100	INTENSIVE CARE UNIT	7,534,132		7,534,132	31.00
40.00	04000	SUBPROVIDER - I/PF	0		0	40.00
41.00	04100	SUBPROVIDER - I/RP	4,139,442		4,139,442	41.00
42.00	04200	SUBPROVIDER	0		0	42.00
43.00	04300	NURSERY	2,239,488		2,239,488	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,593,665	55,626,866	91,220,531	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,462,337	20,814,709	22,277,046	54.00
57.00	05700	CT SCAN	4,235,059	31,936,324	36,171,383	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	370,088	3,577,228	3,947,316	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,949,119	6,420,461	9,369,580	59.00
60.00	06000	LABORATORY	2,396,233	9,756,306	12,152,539	60.00
60.01	06001	ONCOLOGY	24,853	4,908,946	4,933,799	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	3,047,700	5,604,773	8,652,473	65.00
66.00	06600	PHYSICAL THERAPY	5,464,757	6,146,749	11,611,506	66.00
69.00	06900	ELECTROCARDIOLOGY	3,716,410	5,764,185	9,480,595	69.00
69.01	06901	CARDIAC REHAB	0	790,438	790,438	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,759,275	44,709,428	51,468,703	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	498,190	498,190	90.00
91.00	09100	EMERGENCY	8,063,193	52,475,729	60,538,922	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,036,471	6,036,471	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,035,197	4,035,197	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	105,543,861	259,102,000	364,645,861	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	105,543,861	259,102,000	364,645,861	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/23/2015 7:14 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - I PF		40.00
41.00	04100	SUBPROVIDER - I RF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.180218	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.435386	54.00
57.00	05700	CT SCAN	0.043112	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.306979	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.416330	59.00
60.00	06000	LABORATORY	0.942643	60.00
60.01	06001	ONCOLOGY	0.533047	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	60.02
65.00	06500	RESPIRATORY THERAPY	0.470186	65.00
66.00	06600	PHYSICAL THERAPY	0.311586	66.00
69.00	06900	ELECTROCARDIOLOGY	0.247131	69.00
69.01	06901	CARDIAC REHAB	0.597875	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.245057	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.956866	90.00
91.00	09100	EMERGENCY	0.179074	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.686917	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0.614012	95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet C
Part I
Date/Time Prepared:
11/23/2015 7:14 am

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	22,390,597	22,390,597	0	22,390,597	30.00
31.00	03100 INTENSIVE CARE UNIT	6,635,042	6,635,042	0	6,635,042	31.00
40.00	04000 SUBPROVIDER - I/PF	0	0	0	0	40.00
41.00	04100 SUBPROVIDER - I/RF	4,146,630	4,146,630	0	4,146,630	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	42.00
43.00	04300 NURSERY	1,946,496	1,946,496	0	1,946,496	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	16,439,540	16,439,540	0	16,439,540	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	9,699,122	9,699,122	0	9,699,122	54.00
57.00	05700 CT SCAN	1,559,412	1,559,412	0	1,559,412	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,211,742	1,211,742	0	1,211,742	58.00
59.00	05900 CARDIAC CATHETERIZATION	3,900,834	3,900,834	0	3,900,834	59.00
60.00	06000 LABORATORY	11,455,510	11,455,510	0	11,455,510	60.00
60.01	06001 ONCOLOGY	2,629,946	2,629,946	0	2,629,946	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	4,068,270	4,068,270	0	4,068,270	65.00
66.00	06600 PHYSICAL THERAPY	3,617,977	3,617,977	0	3,617,977	66.00
69.00	06900 ELECTROCARDIOLOGY	2,342,948	2,342,948	0	2,342,948	69.00
69.01	06901 CARDIAC REHAB	472,583	472,583	0	472,583	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	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	12,612,790	12,612,790	0	12,612,790	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	974,891	974,891	0	974,891	90.00
91.00	09100 EMERGENCY	10,840,932	10,840,932	0	10,840,932	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,146,556	4,146,556	0	4,146,556	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	2,477,659	2,477,659	0	2,477,659	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	123,569,477	123,569,477	0	123,569,477	200.00
201.00	Less Observation Beds	4,146,556	4,146,556	0	4,146,556	201.00
202.00	Total (see instructions)	119,422,921	119,422,921	0	119,422,921	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet C
Part I
Date/Time Prepared:
11/23/2015 7:14 am

		Title XIX			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,548,110		17,548,110		30.00
31.00	03100	INTENSIVE CARE UNIT	7,534,132		7,534,132		31.00
40.00	04000	SUBPROVIDER - I/PF	0		0		40.00
41.00	04100	SUBPROVIDER - I/RP	4,139,442		4,139,442		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	2,239,488		2,239,488		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	35,593,665	55,626,866	91,220,531	0.180218	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,462,337	20,814,709	22,277,046	0.435386	54.00
57.00	05700	CT SCAN	4,235,059	31,936,324	36,171,383	0.043112	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	370,088	3,577,228	3,947,316	0.306979	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,949,119	6,420,461	9,369,580	0.416330	59.00
60.00	06000	LABORATORY	2,396,233	9,756,306	12,152,539	0.942643	60.00
60.01	06001	ONCOLOGY	24,853	4,908,946	4,933,799	0.533047	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0.000000	60.02
65.00	06500	RESPIRATORY THERAPY	3,047,700	5,604,773	8,652,473	0.470186	65.00
66.00	06600	PHYSICAL THERAPY	5,464,757	6,146,749	11,611,506	0.311586	66.00
69.00	06900	ELECTROCARDIOLOGY	3,716,410	5,764,185	9,480,595	0.247131	69.00
69.01	06901	CARDIAC REHAB	0	790,438	790,438	0.597875	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,759,275	44,709,428	51,468,703	0.245057	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	498,190	498,190	1.956866	90.00
91.00	09100	EMERGENCY	8,063,193	52,475,729	60,538,922	0.179074	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,036,471	6,036,471	0.686917	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	4,035,197	4,035,197	0.614012	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	105,543,861	259,102,000	364,645,861		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	105,543,861	259,102,000	364,645,861		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/23/2015 7:14 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 ONCOLOGY	0.000000		60.01
60.02	06002 RADIATION ONCOLOGY	0.000000		60.02
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901 CARDIAC REHAB	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	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
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
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part I Date/Time Prepared: 11/23/2015 7:14 am
		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	2,645,317	0	2,645,317	17,598	150.32	30.00
31.00	INTENSIVE CARE UNIT	627,678		627,678	3,722	168.64	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	539,778	0	539,778	3,240	166.60	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	37,181		37,181	1,945	19.12	43.00
200.00	Total (Lines 30-199)	3,849,954		3,849,954	26,505		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	6,834	1,027,287				
31.00	INTENSIVE CARE UNIT	1,588	267,800				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	2,646	440,824				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	11,068	1,735,911				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part II Date/Time Prepared: 11/23/2015 7:14 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,870,001	91,220,531	0.020500	12,336,015	252,888	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,109,787	22,277,046	0.049818	841,030	41,898	54.00
57.00	05700	CT SCAN	97,219	36,171,383	0.002688	2,460,430	6,614	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	219,495	3,947,316	0.055606	185,912	10,338	58.00
59.00	05900	CARDIAC CATHETERIZATION	291,924	9,369,580	0.031157	959,357	29,891	59.00
60.00	06000	LABORATORY	768,110	12,152,539	0.063206	1,209,614	76,455	60.00
60.01	06001	ONCOLOGY	44,975	4,933,799	0.009116	12,230	111	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0.000000	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	290,127	8,652,473	0.033531	1,601,867	53,712	65.00
66.00	06600	PHYSICAL THERAPY	107,005	11,611,506	0.009215	1,624,246	14,967	66.00
69.00	06900	ELECTROCARDIOLOGY	405,617	9,480,595	0.042784	2,079,217	88,957	69.00
69.01	06901	CARDIAC REHAB	70,412	790,438	0.089080	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	329,020	51,468,703	0.006393	3,034,962	19,403	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	146,977	498,190	0.295022	0	0	90.00
91.00	09100	EMERGENCY	757,766	60,538,922	0.012517	3,795,263	47,505	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	489,891	6,036,471	0.081155	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	6,998,326	329,149,492		30,140,143	642,739	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part III Date/Time Prepared: 11/23/2015 7:14 am
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Cost Center Description			Title XVIII				Hospital	
			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)	PPS
			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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
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	17,598	0.00	6,834	0		30.00
31.00	03100	INTENSIVE CARE UNIT	3,722	0.00	1,588	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	3,240	0.00	2,646	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	1,945	0.00	0	0		43.00
200.00		Total (lines 30-199)	26,505		11,068	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet D
Part IV
Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description		Title XVIII				Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	ONCOLOGY	0	0	0	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet D
Part IV
Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII		Hospital		Inpatient Program Charges	
			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)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	91,220,531	0.000000	0.000000	12,336,015	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,277,046	0.000000	0.000000	841,030	54.00
57.00	05700	CT SCAN	0	36,171,383	0.000000	0.000000	2,460,430	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,947,316	0.000000	0.000000	185,912	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,369,580	0.000000	0.000000	959,357	59.00
60.00	06000	LABORATORY	0	12,152,539	0.000000	0.000000	1,209,614	60.00
60.01	06001	ONCOLOGY	0	4,933,799	0.000000	0.000000	12,230	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0.000000	0.000000	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	8,652,473	0.000000	0.000000	1,601,867	65.00
66.00	06600	PHYSICAL THERAPY	0	11,611,506	0.000000	0.000000	1,624,246	66.00
69.00	06900	ELECTROCARDIOLOGY	0	9,480,595	0.000000	0.000000	2,079,217	69.00
69.01	06901	CARDIAC REHAB	0	790,438	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	51,468,703	0.000000	0.000000	3,034,962	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	498,190	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	60,538,922	0.000000	0.000000	3,795,263	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,036,471	0.000000	0.000000	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0.000000	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	329,149,492			30,140,143	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/23/2015 7:14 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	14,230,475	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	6,258,839	0	54.00
57.00	05700 CT SCAN	0	9,223,094	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,140,823	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	3,252,392	0	59.00
60.00	06000 LABORATORY	0	1,530,824	0	60.00
60.01	06001 ONCOLOGY	0	1,872,089	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0	1,703,704	0	65.00
66.00	06600 PHYSICAL THERAPY	0	112	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	2,010,881	0	69.00
69.01	06901 CARDIAC REHAB	0	433,920	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	22,201,935	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	216,365	0	90.00
91.00	09100 EMERGENCY	0	10,892,202	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,247,985	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	76,215,640	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet D
Part V
Date/Time Prepared:
11/23/2015 7:14 am

		Title XVIII		Hospital		PPS	
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.180218	14,230,475	0	0	2,564,588	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.435386	6,258,839	0	0	2,725,011	54.00
57.00	05700 CT SCAN	0.043112	9,223,094	0	0	397,626	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.306979	1,140,823	0	0	350,209	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.416330	3,252,392	0	0	1,354,068	59.00
60.00	06000 LABORATORY	0.942643	1,530,824	3,070	0	1,443,021	60.00
60.01	06001 ONCOLOGY	0.533047	1,872,089	0	0	997,911	60.01
60.02	06002 RADIATION ONCOLOGY	0.000000	0	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0.470186	1,703,704	0	0	801,058	65.00
66.00	06600 PHYSICAL THERAPY	0.311586	112	0	0	35	66.00
69.00	06900 ELECTROCARDIOLOGY	0.247131	2,010,881	0	0	496,951	69.00
69.01	06901 CARDIAC REHAB	0.597875	433,920	0	0	259,430	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.245057	22,201,935	0	23,533	5,440,740	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1.956866	216,365	0	0	423,397	90.00
91.00	09100 EMERGENCY	0.179074	10,892,202	0	0	1,950,510	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.686917	1,247,985	0	0	857,262	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.614012		0			95.00
200.00	Subtotal (see instructions)		76,215,640	3,070	23,533	20,061,817	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		76,215,640	3,070	23,533	20,061,817	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/23/2015 7:14 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	2,894	0		60.00
60.01 06001 ONCOLOGY	0	0		60.01
60.02 06002 RADIATION ONCOLOGY	0	0		60.02
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
69.01 06901 CARDIAC REHAB	0	0		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	5,767		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	2,894	5,767		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	2,894	5,767		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150011 Component CCN: 15T011		Period: From 07/01/2014 To 06/30/2015		Worksheet D Part II Date/Time Prepared: 11/23/2015 7:14 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,870,001	91,220,531	0.020500	69,650	1,428	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,109,787	22,277,046	0.049818	33,335	1,661	54.00
57.00	05700 CT SCAN	97,219	36,171,383	0.002688	61,718	166	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	219,495	3,947,316	0.055606	9,997	556	58.00
59.00	05900 CARDIAC CATHETERIZATION	291,924	9,369,580	0.031157	2,985	93	59.00
60.00	06000 LABORATORY	768,110	12,152,539	0.063206	70,065	4,429	60.00
60.01	06001 ONCOLOGY	44,975	4,933,799	0.009116	885	8	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0.000000	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	290,127	8,652,473	0.033531	85,264	2,859	65.00
66.00	06600 PHYSICAL THERAPY	107,005	11,611,506	0.009215	2,303,677	21,228	66.00
69.00	06900 ELECTROCARDIOLOGY	405,617	9,480,595	0.042784	37,683	1,612	69.00
69.01	06901 CARDIAC REHAB	70,412	790,438	0.089080	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	329,020	51,468,703	0.006393	380,701	2,434	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	146,977	498,190	0.295022	0	0	90.00
91.00	09100 EMERGENCY	757,766	60,538,922	0.012517	37,529	470	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	6,036,471	0.000000	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	6,508,435	329,149,492		3,093,489	36,944	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150011 Component CCN: 15T011	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/23/2015 7:14 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 ONCOLOGY	0	0	0	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150011 Component CCN: 15T011		Period: From 07/01/2014 To 06/30/2015		Worksheet D Part IV Date/Time Prepared: 11/23/2015 7:14 am		
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	91,220,531	0.000000	0.000000	69,650	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,277,046	0.000000	0.000000	33,335	54.00
57.00	05700	CT SCAN	0	36,171,383	0.000000	0.000000	61,718	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,947,316	0.000000	0.000000	9,997	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,369,580	0.000000	0.000000	2,985	59.00
60.00	06000	LABORATORY	0	12,152,539	0.000000	0.000000	70,065	60.00
60.01	06001	ONCOLOGY	0	4,933,799	0.000000	0.000000	885	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0.000000	0.000000	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	8,652,473	0.000000	0.000000	85,264	65.00
66.00	06600	PHYSICAL THERAPY	0	11,611,506	0.000000	0.000000	2,303,677	66.00
69.00	06900	ELECTROCARDIOLOGY	0	9,480,595	0.000000	0.000000	37,683	69.00
69.01	06901	CARDIAC REHAB	0	790,438	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	51,468,703	0.000000	0.000000	380,701	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	498,190	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	60,538,922	0.000000	0.000000	37,529	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,036,471	0.000000	0.000000	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0.000000	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	329,149,492			3,093,489	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150011 Component CCN: 15T011	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/23/2015 7:14 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 ONCOLOGY	0	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/23/2015 7:14 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		17,598	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,598	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)		14,339	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)		6,834	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		22,390,597	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)		22,390,597	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		22,390,597	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,272.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,695,172	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)		8,695,172	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 11/23/2015 7:14 am	
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	6,635,042	3,722	1,782.66	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					7,495,130		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					16,190,302		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)					1,295,087		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					642,739		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,937,826		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					14,252,476		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					3,259		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,272.34		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					4,146,556		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/23/2015 7:14 am	
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	2,645,317	22,390,597	0.118144	4,146,556	489,891	90.00
91.00	Nursing School cost	0	22,390,597	0.000000	4,146,556	0	91.00
92.00	Allied health cost	0	22,390,597	0.000000	4,146,556	0	92.00
93.00	All other Medical Education	0	22,390,597	0.000000	4,146,556	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1
		Component CCN: 15T011		Date/Time Prepared: 11/23/2015 7:14 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,240	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,240	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)		3,240	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,646	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,146,630	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,146,630	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,146,630	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,279.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,386,404	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)		3,386,404	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1	
		Component CCN: 15T011				Date/Time Prepared: 11/23/2015 7:14 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					967,767		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,354,171		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)					440,824		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					36,944		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					477,768		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,876,403		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011 Component CCN: 15T011		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/23/2015 7:14 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	539,778	4,146,630	0.130173	0	0	90.00
91.00	Nursing School cost	0	4,146,630	0.000000	0	0	91.00
92.00	Allied health cost	0	4,146,630	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,146,630	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 11/23/2015 7:14 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		17,598	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,598	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)		14,339	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,549	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,945	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		22,390,597	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)		22,390,597	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		22,390,597	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,272.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,970,855	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,970,855	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/23/2015 7:14 am	
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)	
Title XIX		1.00	2.00	3.00	4.00	5.00	
Hospital							
Cost							
42.00	NURSERY (title V & XIX only)	1,946,496	1,945	1,000.77	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	6,635,042	3,722	1,782.66	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,132,530	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,103,385	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					3,259	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,272.34	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,146,556	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/23/2015 7:14 am	
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	2,645,317	22,390,597	0.118144	4,146,556	489,891	90.00
91.00	Nursing School cost	0	22,390,597	0.000000	4,146,556	0	91.00
92.00	Allied health cost	0	22,390,597	0.000000	4,146,556	0	92.00
93.00	All other Medical Education	0	22,390,597	0.000000	4,146,556	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1
		Component CCN: 15T011		Date/Time Prepared: 11/23/2015 7:14 am
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,240	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,240	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)		3,240	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)		115	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,945	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,146,630	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,146,630	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,146,630	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,279.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		147,179	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)		147,179	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1	
		Component CCN: 15T011				Date/Time Prepared: 11/23/2015 7:14 am	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					36,015		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					183,194		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011 Component CCN: 15T011		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/23/2015 7:14 am	
		Title XIX		Subprovider - IRF		Cost	
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	539,778	4,146,630	0.130173	0	0	90.00
91.00	Nursing School cost	0	4,146,630	0.000000	0	0	91.00
92.00	Allied health cost	0	4,146,630	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,146,630	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Prepared: 11/23/2015 7:14 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		8,115,050	30.00
31.00	03100	INTENSIVE CARE UNIT		3,445,960	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.180218	12,336,015	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.435386	841,030	54.00
57.00	05700	CT SCAN	0.043112	2,460,430	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.306979	185,912	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.416330	959,357	59.00
60.00	06000	LABORATORY	0.942643	1,209,614	60.00
60.01	06001	ONCOLOGY	0.533047	12,230	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.470186	1,601,867	65.00
66.00	06600	PHYSICAL THERAPY	0.311586	1,624,246	66.00
69.00	06900	ELECTROCARDIOLOGY	0.247131	2,079,217	69.00
69.01	06901	CARDIAC REHAB	0.597875	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.245057	3,034,962	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.956866	0	90.00
91.00	09100	EMERGENCY	0.179074	3,795,263	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.686917	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		30,140,143	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)		30,140,143	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150011 Component CCN: 15T011	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Prepared: 11/23/2015 7:14 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		3,415,223	41.00
42.00	04200 SUBPROVIDER		0	42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.180218	69,650	12,552 50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0 51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.435386	33,335	14,514 54.00
57.00	05700 CT SCAN	0.043112	61,718	2,661 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.306979	9,997	3,069 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.416330	2,985	1,243 59.00
60.00	06000 LABORATORY	0.942643	70,065	66,046 60.00
60.01	06001 ONCOLOGY	0.533047	885	472 60.01
60.02	06002 RADIATION ONCOLOGY	0.000000	0	0 60.02
65.00	06500 RESPIRATORY THERAPY	0.470186	85,264	40,090 65.00
66.00	06600 PHYSICAL THERAPY	0.311586	2,303,677	717,794 66.00
69.00	06900 ELECTROCARDIOLOGY	0.247131	37,683	9,313 69.00
69.01	06901 CARDIAC REHAB	0.597875	0	0 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.245057	380,701	93,293 73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	1.956866	0	0 90.00
91.00	09100 EMERGENCY	0.179074	37,529	6,720 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.686917	0	0 92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0 92.01
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			
200.00	Total (sum of lines 50-94 and 96-98)		3,093,489	967,767 200.00
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)		3,093,489	967,767 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Prepared: 11/23/2015 7:14 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.180218	1,918,099	345,676	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.435386	101,261	44,088	54.00
57.00	05700 CT SCAN	0.043112	329,594	14,209	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.306979	20,983	6,441	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.416330	214,286	89,214	59.00
60.00	06000 LABORATORY	0.942643	191,741	180,743	60.00
60.01	06001 ONCOLOGY	0.533047	2,176	1,160	60.01
60.02	06002 RADIATION ONCOLOGY	0.000000	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0.470186	265,989	125,064	65.00
66.00	06600 PHYSICAL THERAPY	0.311586	105,701	32,935	66.00
69.00	06900 ELECTROCARDIOLOGY	0.247131	187,758	46,401	69.00
69.01	06901 CARDIAC REHAB	0.597875	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.245057	547,065	134,062	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1.956866	0	0	90.00
91.00	09100 EMERGENCY	0.179074	628,441	112,537	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.686917	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		4,513,094	1,132,530	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)		4,513,094		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3
		Component CCN: 15T011	Date/Time Prepared: 11/23/2015 7:14 am	
		Title XIX	Subprovider - IRF	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		147,111	41.00
42.00	04200 SUBPROVIDER		0	42.00
43.00	04300 NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.180218	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.435386	212	54.00
57.00	05700 CT SCAN	0.043112	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.306979	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.416330	0	59.00
60.00	06000 LABORATORY	0.942643	938	60.00
60.01	06001 ONCOLOGY	0.533047	0	60.01
60.02	06002 RADIATION ONCOLOGY	0.000000	0	60.02
65.00	06500 RESPIRATORY THERAPY	0.470186	3,407	65.00
66.00	06600 PHYSICAL THERAPY	0.311586	102,216	66.00
69.00	06900 ELECTROCARDIOLOGY	0.247131	0	69.00
69.01	06901 CARDIAC REHAB	0.597875	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.245057	6,481	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	1.956866	0	90.00
91.00	09100 EMERGENCY	0.179074	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.686917	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50-94 and 96-98)		113,254	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)		113,254	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prepared: 11/23/2015 7:14 am	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		3,084,362		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		10,751,505		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)		29,836		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)		88.07		4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prepared: 11/23/2015 7:14 am	
		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
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.58		30.00
31.00	Percentage of Medicaid patient days (see instructions)		23.59		31.00
32.00	Sum of lines 30 and 31		29.17		32.00
33.00	Allowable disproportionate share percentage (see instructions)		13.28		33.00
34.00	Disproportionate share adjustment (see instructions)		459,351		34.00
			Prior to October 1	On/After October 1	
		0	1.00	1.01	2.00
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000135796	0.000147542	35.01
35.02	Hospital uncompensated care payment (if line 34 is zero, enter zero on this line) (see instructions)		1,228,462	1,128,346	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		309,640	843,941	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,153,581		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	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)		15,478,635		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		15,057,094		48.00
49.00	Total payment for inpatient operating costs (see instructions)		15,478,635		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,111,841		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		3,175		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)		16,593,651		59.00
60.00	Primary payer payments		10,011		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		16,583,640		61.00
62.00	Deductibles billed to program beneficiaries		1,839,492		62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prepared: 11/23/2015 7:14 am	
		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		10,545		63.00
64.00	Allowable bad debts (see instructions)		136,420		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		88,673		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		29,139		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		14,822,276		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)		16,822		70.93
70.94	HRR adjustment amount (see instructions)		0		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)		14,839,098		71.00
71.01	Sequestration adjustment (see instructions)		296,782		71.01
72.00	Interim payments		14,995,537		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)		-453,221		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,143,305		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prepared: 11/23/2015 7:14 am
		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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/23/2015 7:14 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,084,362	0	3,084,362	0	3,084,362	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,751,505	0	0	10,751,505	10,751,505	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	29,836	0	5,125	24,711	29,836	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1328	0.1328	0.1328	0.1328		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	459,351	0	102,401	356,950	459,351	11.00
11.01	Uncompensated care payments	36.00	1,153,581	0	309,640	631,221	940,861	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	15,478,635	0	3,501,528	11,977,107	15,478,635	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	15,057,094	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,478,635	0	3,501,528	11,977,107	15,478,635	15.00
16.00	Payment for inpatient program capital	50.00	1,111,841	0	247,742	864,099	1,111,841	16.00
17.00	Special add-on payments for new technologies	54.00	3,175	0	1,588	1,588	3,176	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/23/2015 7:14 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	3,750,858	12,842,794	16,593,652	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,105,756	0	246,538	859,217	1,105,755	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,085	0	1,204	4,882	6,086	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,111,841	0	247,742	864,099	1,111,841	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/23/2015 7:14 am
Title XVIII			Hospital	PPS

	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col. 2 and 3)	
	0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00				1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,084,362	3,084,362		3,084,362
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,751,505		10,751,505	10,751,505
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00	29,836	5,125	24,711	29,836
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0
Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0
Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1328	0.1328	0.1328	
11.00	Disproportionate share adjustment (see instructions)	34.00	459,351	102,401	356,950	459,351
11.01	Uncompensated care payments	36.00	1,153,581	309,640	631,221	940,861
Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0
13.00	Subtotal (see instructions)	47.00	15,478,635	3,501,528	11,977,107	15,478,635
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	15,057,094	3,300,687	11,756,407	15,057,094
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,478,635	3,501,528	11,977,107	15,478,635
16.00	Payment for inpatient program capital	50.00	1,111,841	247,742	864,099	1,111,841
17.00	Special add-on payments for new technologies	54.00	3,175	1,587	1,588	3,175
17.01	Net organ acquisition cost	55.00	0	0	0	0
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0
19.00	SUBTOTAL			3,750,857	12,842,794	16,593,651

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/23/2015 7:14 am

		Title XVIII			Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	1,105,756	246,538	859,218	1,105,756	20.00	
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01	
21.00	Capital DRG outlier payments	2.00	6,085	1,204	4,881	6,085	21.00	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	1,111,841	247,742	864,099	1,111,841	26.00	
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)					
		0	1.00	2.00	3.00	4.00		
27.00							27.00	
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00	
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00	
30.00	HVBP payment adjustment (see instructions)	70.93	16,822	-8,252	25,074	16,822	30.00	
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01	
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00	
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01	
						(Amt. to Wkst. E, Pt. A)		
		0	1.00	2.00	3.00	4.00		
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/23/2015 7:14 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,661	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		20,061,817	2.00
3.00	PPS payments		16,830,939	3.00
4.00	Outlier payment (see instructions)		115,678	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)		8,661	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		26,603	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		26,603	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		26,603	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		17,942	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)		8,661	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)		16,946,617	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,537,165	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		13,418,113	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)		13,418,113	30.00
31.00	Primary payer payments		1,915	31.00
32.00	Subtotal (line 30 minus line 31)		13,416,198	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		898,563	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		584,066	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		661,278	36.00
37.00	Subtotal (see instructions)		14,000,264	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)		14,000,264	40.00
40.01	Sequestration adjustment (see instructions)		280,005	40.01
41.00	Interim payments		13,537,339	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		182,920	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
11/23/2015 7:14 am

		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		14,895,339		13,143,309	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	06/30/2015	100,198	06/30/2015	394,030	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		100,198		394,030	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)		14,995,537		13,537,339	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		182,920	6.01	
6.02	SETTLEMENT TO PROGRAM		453,221		0	6.02	
7.00	Total Medicare program liability (see instructions)		14,542,316		13,720,259	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150011
Component CCN: 15T011

Period:
From 07/01/2014
To 06/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
11/23/2015 7:14 am
PPS

Title XVIII

Subprovider -
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider				0	1.00
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		4,104,768		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,104,768		0	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		18,229		0	6.02
7.00	Total Medicare program liability (see instructions)		4,086,539		0	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: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet E-1
Part II
Date/Time Prepared:
11/23/2015 7:14 am

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			4,998 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			8,422 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			2,178 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			18,061 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			364,645,861 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			53,575,785 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)			1,429,217 8.00
9.00	Sequestration adjustment amount (see instructions)			28,584 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,400,633 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,047,642 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)			352,991 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011 Component CCN: 15T011	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part III Date/Time Prepared: 11/23/2015 7:14 am
		Title XVIIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			4,032,275 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0186 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			87,500 3.00
4.00	Outlier Payments			102,701 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			8.876712 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			4,222,476 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			4,222,476 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			4,222,476 19.00
20.00	Deductibles			43,220 20.00
21.00	Subtotal (line 19 minus line 20)			4,179,256 21.00
22.00	Coinsurance			9,318 22.00
23.00	Subtotal (line 21 minus line 22)			4,169,938 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			4,169,938 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			4,169,938 32.00
32.01	Sequestration adjustment (see instructions)			83,399 32.01
33.00	Interim payments			4,104,768 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)			-18,229 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			167,920 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			102,701 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 11/23/2015 7:14 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		3,103,385		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		3,103,385	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		3,103,385	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		2,240,197		8.00
9.00	Ancillary service charges		4,513,094	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		6,753,291	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		6,753,291	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		3,649,906	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		3,103,385	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		3,103,385	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		3,103,385	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		3,103,385	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		3,103,385	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		3,103,385	0	40.00
41.00	Interim payments		3,595,376	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-491,991	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011 Component CCN: 15T011	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 11/23/2015 7:14 am
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	183,194		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	183,194	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	183,194	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	148,711		8.00
9.00	Ancillary service charges	113,254	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	261,965	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	261,965	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	78,771	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	183,194	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	183,194	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	183,194	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	183,194	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	183,194	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	183,194	0	40.00
41.00	Interim payments	148,569	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	34,625	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet G

Date/Time Prepared:
11/23/2015 7:14 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	28,858,498	0	0	0	1.00
2.00	Temporary investments	2,450,350	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	45,563,515	0	0	0	4.00
5.00	Other receivable	8,186,805	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-28,088,425	0	0	0	6.00
7.00	Inventory	1,716,593	0	0	0	7.00
8.00	Prepaid expenses	1,969,468	0	0	0	8.00
9.00	Other current assets	717,611	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)	61,374,415	0	0	0	11.00
FIXED ASSETS						
12.00	Land	4,422,248	0	0	0	12.00
13.00	Land improvements	3,341,756	0	0	0	13.00
14.00	Accumulated depreciation	-1,945,208	0	0	0	14.00
15.00	Buildings	108,209,879	0	0	0	15.00
16.00	Accumulated depreciation	-59,249,996	0	0	0	16.00
17.00	Leasehold improvements	871,326	0	0	0	17.00
18.00	Accumulated depreciation	-704,239	0	0	0	18.00
19.00	Fixed equipment	1,005,608	0	0	0	19.00
20.00	Accumulated depreciation	-845,381	0	0	0	20.00
21.00	Automobiles and trucks	1,102,002	0	0	0	21.00
22.00	Accumulated depreciation	-823,171	0	0	0	22.00
23.00	Major movable equipment	76,756,278	0	0	0	23.00
24.00	Accumulated depreciation	-59,484,160	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	4,957,546	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	77,614,488	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	185,780,343	10,155	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	9,127,251	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	194,907,594	10,155	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	333,896,497	10,155	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	5,344,784	0	0	0	37.00
38.00	Salaries, wages, and fees payable	10,137,126	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,324,278	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	18,806,188	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	80,153,072	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	80,153,072	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	98,959,260	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	234,937,237				52.00
53.00	Specific purpose fund		10,155			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)	234,937,237	10,155	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	333,896,497	10,155	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet G-1

Date/Time Prepared:
11/23/2015 7:14 am

		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		234,742,572		10,155	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		194,665			2.00
3.00	Total (sum of line 1 and line 2)		234,937,237		10,155	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)		234,937,237		10,155	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)		234,937,237		10,155	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: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/23/2015 7:14 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	19,032,096		19,032,096	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	3,641,022		3,641,022	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	22,673,118		22,673,118	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	7,541,676		7,541,676	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)	7,541,676		7,541,676	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	30,214,794		30,214,794	17.00
18.00	Ancillary services	75,827,542		75,827,542	18.00
19.00	Outpatient services	0	259,560,086	259,560,086	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	4,046,624	4,046,624	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN	0	25,562,958	25,562,958	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	106,042,336	289,169,668	395,212,004	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		152,327,631		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)		152,327,631		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150011

Period:
From 07/01/2014
To 06/30/2015

Worksheet G-3

Date/Time Prepared:
11/23/2015 7:14 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	395,212,004	1.00
2.00	Less contractual allowances and discounts on patients' accounts	238,702,839	2.00
3.00	Net patient revenues (line 1 minus line 2)	156,509,165	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	152,327,631	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,181,534	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-8,246,320	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	4,256,643	24.00
25.00	Total other income (sum of lines 6-24)	-3,989,677	25.00
26.00	Total (line 5 plus line 25)	191,857	26.00
27.00	BAD DEBT EXPENSE	-2,808	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-2,808	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	194,665	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150011	Period: From 07/01/2014 To 06/30/2015	Worksheet L Parts I-III Date/Time Prepared: 11/23/2015 7:14 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,105,756	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		6,085	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)		50.12	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,111,841	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00