

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: 150042
Period: From 01/01/2015 To 12/31/2015
Worksheet S
Parts I-III
Date/Time Prepared: 5/25/2016 11:59 am

PART I - COST REPORT STATUS

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

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

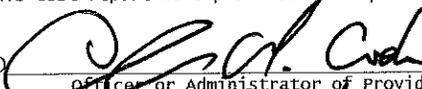
Date: 5/25/2016 Time: 11:59 am

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 GOOD SAMARITAN HOSPITAL (150042) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) 
 Officer or Administrator of Provider(s)
 Chief Financial Officer
 Title
 Date 5/25/2016

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	172,797	92,884	-3,957	0	1.00
2.00 Subprovider - IPF	0	10,727	418		0	2.00
3.00 Subprovider - IRF	0	32,463	161		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	215,987	93,463	-3,957	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 9:57 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.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N		N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N		N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N		N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N		N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y		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)			N	N	0
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	2.00	3.00
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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/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:	1,181,805	54,004		0	118.01
					1.00	
					2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			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	

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		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	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				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)				0.25		
		Beginni ng		Endi ng			
		1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2015		12/31/2015			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 9:57 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: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/25/2016 9:57 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)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/22/2016	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150042

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

Worksheet S-2
Part II
Date/Time Prepared:
5/25/2016 9:57 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			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			Y	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				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.	RENEE		ESSLINGER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3173833768		RESSLINGER@BKD.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)	03/22/2016		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGING CONSULTANT		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: 150042

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

Worksheet S-3
Part I
Date/Time Prepared:
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Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	162	61,490	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)		162	61,490	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	30	8,590	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)		192	70,080	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	22	8,030		0	16.00
17.00 SUBPROVIDER - IRF	41.00	25	9,125		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		239				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: 150042

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

Worksheet S-3
Part I
Date/Time Prepared:
5/25/2016 9:57 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)	10,646	537	16,248			1.00
2.00 HMO and other (see instructions)	1,247	2,622				2.00
3.00 HMO IPF Subprovider	47	0				3.00
4.00 HMO IRF Subprovider	92	306				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)	10,646	537	16,248			7.00
8.00 INTENSIVE CARE UNIT	3,158	223	6,762			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		35	1,051			13.00
14.00 Total (see instructions)	13,804	795	24,061	0.00	1,481.63	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,868	0	4,219	0.00	29.39	16.00
17.00 SUBPROVIDER - IRF	6,500	67	8,049	0.00	55.43	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	11.96	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	1,578.41	27.00
28.00 Observation Bed Days		0	1,859			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	61	114			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: 150042

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

Worksheet S-3
Part I
Date/Time Prepared:
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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	3,126	1,002	6,276	1.00
2.00 HMO and other (see instructions)			236	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	3,126	1,002	6,276	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	236	304	830	16.00
17.00 SUBPROVIDER - IRF	0.00	0	550	26	655	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part II Date/Time Prepared: 5/25/2016 9:57 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	97,782,467	0	97,782,467	3,380,819.00	28.92	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		276,911	0	276,911	2,523.00	109.75	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		5,071,734	0	5,071,734	28,576.00	177.48	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)		30,962,418	2,210,723	33,173,141	973,097.00	34.09	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		6,863	0	6,863	578.00	11.87	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		293,164	0	293,164	3,018.00	97.14	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)		16,611,112	0	16,611,112			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		6,800,395	0	6,800,395			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		16,540	0	16,540			22.00
22.01	Physician Part A - Teaching		200,846	0	200,846			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	4,338,461	0	4,338,461	260,638.00	16.65	26.00
27.00	Administrative & General	5.00	7,511,272	705,550	8,216,822	269,192.00	30.52	27.00
28.00	Administrative & General under contract (see inst.)		516,773	0	516,773	2,684.00	192.54	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,231,407	141,110	2,372,517	118,317.00	20.05	30.00
31.00	Laundry & Linen Service	8.00	197,882	0	197,882	17,139.00	11.55	31.00
32.00	Housekeeping	9.00	1,928,989	0	1,928,989	146,973.00	13.12	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,326,576	-1,013,386	313,190	21,916.00	14.29	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,013,386	1,013,386	70,913.00	14.29	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,549,512	47,037	1,596,549	42,373.00	37.68	38.00
39.00	Central Services and Supply	14.00	356,396	0	356,396	25,947.00	13.74	39.00
40.00	Pharmacy	15.00	3,233,795	-515,888	2,717,907	71,699.00	37.91	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150042

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

Worksheet S-3
Part II
Date/Time Prepared:
5/25/2016 9:57 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 2,440,400	0	2,440,400	124,459.00	19.61	41.00
42.00	Social Service	17.00 4,703,666	-3,104,420	1,599,246	84,272.00	18.98	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150042

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

Worksheet S-3
Part III
Date/Time Prepared:
5/25/2016 9:57 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	93,227,506	0	93,227,506	3,354,927.00	27.79	1.00
2.00	Excluded area salaries (see instructions)	30,962,418	2,210,723	33,173,141	973,097.00	34.09	2.00
3.00	Subtotal salaries (line 1 minus line 2)	62,265,088	-2,210,723	60,054,365	2,381,830.00	25.21	3.00
4.00	Subtotal other wages & related costs (see inst.)	300,027	0	300,027	3,596.00	83.43	4.00
5.00	Subtotal wage-related costs (see inst.)	16,627,652	0	16,627,652	0.00	27.69	5.00
6.00	Total (sum of lines 3 thru 5)	79,192,767	-2,210,723	76,982,044	2,385,426.00	32.27	6.00
7.00	Total overhead cost (see instructions)	30,335,129	-2,726,611	27,608,518	1,256,522.00	21.97	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part IV Date/Time Prepared: 5/25/2016 9:57 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		5,213,735	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		12,217,200	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		461,649	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		201,207	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)		228,729	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		41,519	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		3,856,723	17.00
18.00	Medicare Taxes - Employers Portion Only		1,090,334	18.00
19.00	Unemployment Insurance		0	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		37,136	22.00
23.00	Tuition Reimbursement		418,191	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		23,766,423	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150042

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

Worksheet S-3
Part V
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	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	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	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: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10	Date/Time Prepared: 5/25/2016 9:57 am	
					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)				0.287343	1.00
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				18,397,368	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid				2,801,927	5.00
6.00	Medicaid charges				64,906,814	6.00
7.00	Medicaid cost (line 1 times line 6)				18,650,519	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)				0	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone SCHIP				0	9.00
10.00	Stand-alone SCHIP charges				0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)				0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)				0	12.00
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)				0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)				0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)				0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)				0	16.00
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care				0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations				0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)				0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)		
		1.00	2.00	3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	4,398,936	6,843,924	11,242,860		
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,264,003	1,966,554	3,230,557		
22.00	Partial payment by patients approved for charity care	64,444	27,486	91,930		
23.00	Cost of charity care (line 21 minus line 22)	1,199,559	1,939,068	3,138,627		
					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)				21,766,056	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)				581,829	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)				21,184,227	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)				6,087,139	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				9,225,766	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				9,225,766	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150042

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

Worksheet A
Date/Time Prepared:
5/25/2016 9:57 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	CAP REL COSTS-BLDG & FIXT	0	0	21,290,407	21,290,407	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		7,065,481	-7,076,964	-11,483	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	624,767	2,488,786	3,113,553	24,253,660	4.00
4.01	00401	COMMUNICATIONS	249,016	99,209	348,225	265,892	4.01
4.02	00402	PURCHASING & RECEIVING	664,965	311,013	975,978	732,848	4.02
4.03	00403	REGISTRATION	806,174	451,476	1,257,650	914,402	4.03
4.04	00404	PATIENT ACCOUNTS	1,993,539	2,896,339	4,889,878	4,185,038	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	7,511,272	22,445,019	29,956,291	24,378,638	5.00
7.00	00700	OPERATION OF PLANT	2,231,407	4,430,826	6,662,233	6,107,511	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	197,882	368,435	566,317	358,583	8.00
9.00	00900	HOUSEKEEPING	1,928,989	1,140,322	3,069,311	2,286,261	9.00
10.00	01000	DIETARY	1,326,576	1,936,284	3,262,860	677,159	10.00
11.00	01100	CAFETERIA	0	0	2,108,675	2,108,675	11.00
13.00	01300	NURSING ADMINISTRATION	1,549,512	903,922	2,453,434	1,953,654	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	356,396	391,397	747,793	548,443	14.00
15.00	01500	PHARMACY	3,233,795	15,309,462	18,543,257	3,081,298	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,440,400	1,741,072	4,181,472	3,424,556	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	4,703,666	3,706,130	8,409,796	2,381,043	17.01
23.00	02300	PARAMED PGRM-(SPECIFY)	190,647	82,354	273,001	224,569	23.00
23.01	02302	PARAMED PGRM-(SPECIFY)	12,081	6,362	18,443	14,602	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,676,255	4,746,140	10,422,395	7,602,098	30.00
31.00	03100	INTENSIVE CARE UNIT	3,466,323	1,802,646	5,268,969	4,002,114	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	755,757	755,757	40.00
41.00	04100	SUBPROVIDER - IRF	2,709,373	1,712,600	4,421,973	3,734,350	41.00
43.00	04300	NURSERY	331,566	167,963	499,529	385,039	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,637,832	5,649,185	9,287,017	5,525,805	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	954,383	1,252,615	2,206,998	1,309,284	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	438,612	232,629	671,241	502,978	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,809,996	6,053,804	9,863,800	6,221,515	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	797,370	944,322	1,741,692	1,177,646	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	268,525	138,776	407,301	341,547	54.08
60.00	06000	LABORATORY	2,438,766	5,080,167	7,518,933	4,286,102	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	834,139	834,139	63.00
65.00	06500	RESPIRATORY THERAPY	1,913,972	949,819	2,863,791	2,199,148	65.00
66.00	06600	PHYSICAL THERAPY	2,492,400	1,017,816	3,510,216	2,848,359	66.00
69.00	06900	ELECTROCARDIOLOGY	4,316,569	2,811,973	7,128,542	5,101,441	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	318,220	195,079	513,299	386,730	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	8,884,046	8,884,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,152,971	2,152,971	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,326	1,743	19,069	14,566,274	73.00
75.00	07500	ASC (NON-DISTINCT PART)	957,020	3,197,741	4,154,761	2,064,589	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	756,830	756,830	673,782	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,589,990	1,239,955	2,829,945	2,063,600	90.00
91.00	09100	EMERGENCY	3,512,751	6,883,298	10,396,049	9,349,857	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	63,817	115,360	179,177	121,934	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		3,095,649	3,095,649	0	113.00
116.00	11600	HOSPICE	634,217	696,336	1,330,553	1,175,359	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	70,366,367	114,516,335	184,882,702	187,442,220	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,366,442	12,219,109	38,585,551	33,892,642	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	150,830	158,475	309,305	240,616	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	169,306	971,147	1,140,453	1,087,044	194.02
194.03	07953	MH RESIDENTIAL	384,948	216,087	601,035	463,741	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	194.04
194.05	07955	MOB	209,629	111,644	321,273	260,721	194.05
194.06	07956	FOUNDATION	117,171	1,110,887	1,228,058	1,208,390	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	17,774	3,369	21,143	20,757	194.08
194.09	07959	NRCC	0	0	0	2,473,389	194.09

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 150042		Period: From 01/01/2015 To 12/31/2015		Worksheet A Date/Time Prepared: 5/25/2016 9:57 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	
200.00	TOTAL (SUM OF LINES 118-199)		97,782,467	129,307,053	227,089,520	0	227,089,520	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150042

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

Worksheet A
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-484,643	20,805,764	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	-11,483	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-370,700	23,882,960	4.00
4.01	00401	COMMUNICATIONS	0	265,892	4.01
4.02	00402	PURCHASING & RECEIVING	-265,301	467,547	4.02
4.03	00403	REGISTRATION	0	914,402	4.03
4.04	00404	PATIENT ACCOUNTS	-231,088	3,953,950	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	-5,462,444	18,916,194	5.00
7.00	00700	OPERATION OF PLANT	-7,897	6,099,614	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	358,583	8.00
9.00	00900	HOUSEKEEPING	0	2,286,261	9.00
10.00	01000	DIETARY	-33,886	643,273	10.00
11.00	01100	CAFETERIA	-983,783	1,124,892	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,953,654	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-11	548,432	14.00
15.00	01500	PHARMACY	-5	3,081,293	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,851	3,421,705	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	-635,186	1,745,857	17.01
23.00	02300	PARAMED PGMR-(SPECIFY)	-56,787	167,782	23.00
23.01	02302	PARAMED PGMR-(SPECIFY)	0	14,602	23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-182	7,601,916	30.00
31.00	03100	INTENSIVE CARE UNIT	-13,125	3,988,989	31.00
40.00	04000	SUBPROVIDER - I/PF	0	755,757	40.00
41.00	04100	SUBPROVIDER - I/RF	-2	3,734,348	41.00
43.00	04300	NURSERY	-1,291	383,748	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,483,350	4,042,455	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
51.01	05101	ENDOSCOPY	-21	1,309,263	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	-56	502,922	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-220,805	6,000,710	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0	1,177,646	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	-142,754	198,793	54.08
60.00	06000	LABORATORY	-61,369	4,224,733	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	834,139	63.00
65.00	06500	RESPIRATORY THERAPY	-15,995	2,183,153	65.00
66.00	06600	PHYSICAL THERAPY	-1,350	2,847,009	66.00
69.00	06900	ELECTROCARDIOLOGY	-2,133,502	2,967,939	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	-13,354	373,376	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,884,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,152,971	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-459,939	14,106,335	73.00
75.00	07500	ASC (NON-DISTINCT PART)	-475	2,064,114	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	-213,351	460,431	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-810,461	1,253,139	90.00
91.00	09100	EMERGENCY	-5,193,432	4,156,425	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	121,934	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-125	1,175,234	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-19,299,521	168,142,699	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33,892,642	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	240,616	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	1,087,044	194.02
194.03	07953	MH RESIDENTIAL	0	463,741	194.03
194.04	07954	UNUSED SPACE	0	0	194.04
194.05	07955	MOB	0	260,721	194.05
194.06	07956	FOUNDATION	0	1,208,390	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	20,757	194.08
194.09	07959	NRCC	0	2,473,389	194.09
200.00		TOTAL (SUM OF LINES 118-199)	-19,299,521	207,789,999	200.00

RECLASSIFICATIONS

Provider CCN: 150042

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

Worksheet A-6

Date/Time Prepared:
5/25/2016 9:57 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	13,782,735	1.00
	O		0	13,782,735	
B - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	8,884,046	1.00
2.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	834,139	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
	O		0	9,718,185	
C - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	21,222,303	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00

RECLASSIFICATIONS

Provider CCN: 150042

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

Worksheet A-6

Date/Time Prepared:
5/25/2016 9:57 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
40.00		0.00	0	0	40.00
41.00		0.00	0	0	41.00
42.00		0.00	0	0	42.00
43.00		0.00	0	0	43.00
44.00		0.00	0	0	44.00
45.00		0.00	0	0	45.00
46.00		0.00	0	0	46.00
47.00		0.00	0	0	47.00
48.00		0.00	0	0	48.00
49.00		0.00	0	0	49.00
0			0	21,222,303	
D - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,090,599	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		5,050	2.00
0			0	3,095,649	
E - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	10,564,243	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
40.00		0.00	0	0	40.00
41.00		0.00	0	0	41.00
42.00		0.00	0	0	42.00
43.00		0.00	0	0	43.00
44.00		0.00	0	0	44.00
45.00		0.00	0	0	45.00
0			0	10,564,243	
G - INSURANCE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	558,601	1.00
12.00		0.00	0	0	12.00
0			0	558,601	

RECLASSIFICATIONS

Provider CCN: 150042

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

Worksheet A-6

Date/Time Prepared:
5/25/2016 9:57 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
H - MENTAL HEALTH OVERHEAD					
1.00	ADMINISTRATIVE & GENERAL	5.00	705,550	325,029	1.00
2.00	OPERATION OF PLANT	7.00	141,110	65,006	2.00
3.00	NURSING ADMINISTRATION	13.00	47,037	21,669	3.00
4.00	SUBPROVIDER - IPF	40.00	517,403	238,354	4.00
5.00	NRCC	194.09	1,693,320	780,069	5.00
			3,104,420	1,430,127	
I - IMPL. DEV. CHARGED TO PATIENT					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,152,971	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
			0	2,152,971	
J - ONCOLOGY					
1.00	DRUGS CHARGED TO PATIENTS	73.00	515,888	250,268	1.00
			515,888	250,268	
K - DIETARY					
1.00	CAFETERIA	11.00	1,013,386	1,095,289	1.00
			1,013,386	1,095,289	
L - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,411,907	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,659,426	2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	521,185	3.00
4.00	CAP REL COSTS-BLDG & FIXT	1.00	0	714,669	4.00
5.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,182,354	5.00
6.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,743	6.00
7.00	CAP REL COSTS-BLDG & FIXT	1.00	0	585,680	7.00
8.00		0.00	0	0	8.00
			0	7,076,964	
500.00	Grand Total: Increases		4,633,694	70,947,335	500.00

RECLASSIFICATIONS

Provider CCN: 150042

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

Worksheet A-6
Date/Time Prepared:
5/25/2016 9:57 am

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - DRUGS CHARGED TO PATIENTS							
1.00	PHARMACY	15.00	0	13,782,735	0		1.00
	O		0	13,782,735			
B - MEDICAL SUPPLIES CHARGED TO PATIENTS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	59,584	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,297	0		2.00
3.00	OPERATION OF PLANT	7.00	0	59	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	6	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,343	0		5.00
6.00	PHARMACY	15.00	0	52,726	0		6.00
7.00	MENTAL HEALTH OVERHEAD	17.01	0	1,400	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	1,082,749	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	69,561	0		9.00
10.00	SUBPROVIDER - IRF	41.00	0	16,124	0		10.00
11.00	NURSERY	43.00	0	9,372	0		11.00
12.00	OPERATING ROOM	50.00	0	826,101	0		12.00
13.00	ENDOSCOPY	51.01	0	315,130	0		13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	29,748	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	887,535	0		15.00
16.00	RADIOLOGY-NON-CAMPUS	54.01	0	36,111	0		16.00
17.00	RADIOLOGY-NON-CAMPUS	54.01	0	36,367	0		17.00
18.00	RADIOLOGY-GSH BREAST CENTER	54.08	0	6,403	0		18.00
19.00	LABORATORY	60.00	0	2,457,370	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	179,781	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	45,598	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	1,041,774	0		22.00
23.00	NEURODIAGNOSTICS	70.01	0	254	0		23.00
24.00	INPATIENT DIALYSIS	76.01	0	3,478	0		24.00
25.00	ASC (NON-DISTINCT PART)	75.00	0	963,448	0		25.00
26.00	CLINIC	90.00	0	425,030	0		26.00
27.00	EMERGENCY	91.00	0	34,460	0		27.00
28.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	35,604	0		28.00
29.00	HOSPICE	116.00	0	7,443	0		29.00
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,064,819	0		30.00
31.00	COMMUNITY HEALTH SERVICES	194.00	0	18,984	0		31.00
32.00	MH RESIDENTIAL	194.03	0	390	0		32.00
33.00	MOB	194.05	0	6,934	0		33.00
34.00	INDUSTRIAL HEALTH	194.08	0	151	0		34.00
35.00	HOUSEKEEPING	9.00	0	51	0		35.00
	O		0	9,718,185			
C - EMPLOYEE BENEFITS							
1.00	COMMUNICATIONS	4.01	0	81,254	0		1.00
2.00	PURCHASING & RECEIVING	4.02	0	225,202	0		2.00
3.00	REGISTRATION	4.03	0	334,039	0		3.00
4.00	PATIENT ACCOUNTS	4.04	0	651,580	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	1,597,060	0		5.00
6.00	OPERATION OF PLANT	7.00	0	522,072	0		6.00
7.00	LAUNDRY & LINEN SERVICE	8.00	0	98,656	0		7.00
8.00	HOUSEKEEPING	9.00	0	741,955	0		8.00
9.00	DIETARY	10.00	0	426,700	0		9.00
10.00	NURSING ADMINISTRATION	13.00	0	317,779	0		10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00	0	143,739	0		11.00
12.00	PHARMACY	15.00	0	697,046	0		12.00
13.00	MEDICAL RECORDS & LIBRARY	16.00	0	740,484	0		13.00
14.00	MENTAL HEALTH OVERHEAD	17.01	0	1,420,650	0		14.00
15.00	PARAMED PGRM-(SPECIFY)	23.00	0	46,380	0		15.00
16.00	PARAMED PGRM-(SPECIFY)	23.01	0	1,409	0		16.00
17.00	ADULTS & PEDIATRICS	30.00	0	1,511,326	0		17.00
18.00	INTENSIVE CARE UNIT	31.00	0	901,026	0		18.00
19.00	SUBPROVIDER - IRF	41.00	0	632,271	0		19.00
20.00	NURSERY	43.00	0	84,116	0		20.00
21.00	OPERATING ROOM	50.00	0	415,948	0		21.00
22.00	ENDOSCOPY	51.01	0	241,003	0		22.00
23.00	DELIVERY ROOM & LABOR ROOM	52.00	0	104,827	0		23.00
24.00	OPERATING ROOM	50.00	0	143,802	0		24.00
25.00	RADIOLOGY-DIAGNOSTIC	54.00	0	850,451	0		25.00
26.00	RADIOLOGY-NON-CAMPUS	54.01	0	13,568	0		26.00
27.00	RADIOLOGY-NON-CAMPUS	54.01	0	4,376	0		27.00
28.00	RADIOLOGY-NON-CAMPUS	54.01	0	105,670	0		28.00
29.00	RADIOLOGY-NON-CAMPUS	54.01	0	35,413	0		29.00
30.00	RADIOLOGY-NON-CAMPUS	54.01	0	20,558	0		30.00
31.00	RADIOLOGY-GSH BREAST CENTER	54.08	0	59,351	0		31.00
32.00	LABORATORY	60.00	0	681,149	0		32.00
33.00	RESPIRATORY THERAPY	65.00	0	435,809	0		33.00

RECLASSIFICATIONS

Provider CCN: 150042

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

Worksheet A-6
Date/Time Prepared:
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
34.00	PHYSICAL THERAPY	66.00	0	598,271	0	34.00	
35.00	ELECTROCARDIOLOGY	69.00	0	627,324	0	35.00	
36.00	NEURODIAGNOSTICS	70.01	0	77,730	0	36.00	
37.00	ASC (NON-DISTINCT PART)	75.00	0	306,479	0	37.00	
38.00	CLINIC	90.00	0	338,802	0	38.00	
39.00	EMERGENCY	91.00	0	906,558	0	39.00	
40.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	20,891	0	40.00	
41.00	HOSPICE	116.00	0	138,488	0	41.00	
42.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,615,846	0	42.00	
43.00	COMMUNITY HEALTH SERVICES	194.00	0	49,353	0	43.00	
44.00	MARKETING AND PUBLIC RELATIONS	194.02	0	45,432	0	44.00	
45.00	MH RESIDENTIAL	194.03	0	135,253	0	45.00	
46.00	MOB	194.05	0	53,618	0	46.00	
47.00	FOUNDATION	194.06	0	19,668	0	47.00	
48.00	INDUSTRIAL HEALTH	194.08	0	235	0	48.00	
49.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,686	0	49.00	
	0		0	21,222,303			
D - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	3,095,649	11	1.00	
2.00		0.00	0	0	0	2.00	
	0		0	3,095,649			
E - DEPRECIATION EXPENSE							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	22,612	9	1.00	
2.00	COMMUNICATIONS	4.01	0	1,079	9	2.00	
3.00	PURCHASING & RECEIVING	4.02	0	17,928	9	3.00	
4.00	REGISTRATION	4.03	0	9,209	9	4.00	
5.00	PATIENT ACCOUNTS	4.04	0	53,260	9	5.00	
6.00	ADMINISTRATIVE & GENERAL	5.00	0	4,456,324	9	6.00	
7.00	OPERATION OF PLANT	7.00	0	238,707	9	7.00	
8.00	LAUNDRY & LINEN SERVICE	8.00	0	109,078	9	8.00	
9.00	HOUSEKEEPING	9.00	0	41,044	9	9.00	
10.00	DIETARY	10.00	0	50,326	9	10.00	
11.00	NURSING ADMINISTRATION	13.00	0	250,701	9	11.00	
12.00	CENTRAL SERVICES & SUPPLY	14.00	0	52,871	9	12.00	
13.00	PHARMACY	15.00	0	163,296	9	13.00	
14.00	MEDICAL RECORDS & LIBRARY	16.00	0	16,432	9	14.00	
15.00	MENTAL HEALTH OVERHEAD	17.01	0	72,156	9	15.00	
16.00	PARAMEDICAL PGRM-(SPECIFY)	23.00	0	2,052	9	16.00	
17.00	PARAMEDICAL PGRM-(SPECIFY)	23.01	0	2,432	9	17.00	
18.00	ADULTS & PEDIATRICS	30.00	0	226,222	9	18.00	
19.00	INTENSIVE CARE UNIT	31.00	0	296,268	9	19.00	
20.00	SUBPROVIDER - IRF	41.00	0	39,228	9	20.00	
21.00	NURSERY	43.00	0	21,002	9	21.00	
22.00	OPERATING ROOM	50.00	0	538,672	9	22.00	
23.00	ENDOSCOPY	51.01	0	341,581	9	23.00	
24.00	DELIVERY ROOM & LABOR ROOM	52.00	0	33,688	9	24.00	
25.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,882,509	9	25.00	
26.00	RADIOLOGY-NON-CAMPUS	54.01	0	240	9	26.00	
27.00	RADIOLOGY-NON-CAMPUS	54.01	0	2,878	9	27.00	
28.00	RADIOLOGY-NON-CAMPUS	54.01	0	221,223	9	28.00	
29.00	RADIOLOGY-NON-CAMPUS	54.01	0	83,745	9	29.00	
30.00	LABORATORY	60.00	0	94,312	9	30.00	
31.00	RESPIRATORY THERAPY	65.00	0	49,053	9	31.00	
32.00	PHYSICAL THERAPY	66.00	0	17,988	9	32.00	
33.00	ELECTROCARDIOLOGY	69.00	0	355,608	9	33.00	
34.00	NEURODIAGNOSTICS	70.01	0	48,585	9	34.00	
35.00	INPATIENT DIALYSIS	76.01	0	79,570	9	35.00	
36.00	ASC (NON-DISTINCT PART)	75.00	0	534,631	9	36.00	
37.00	CLINIC	90.00	0	2,513	9	37.00	
38.00	EMERGENCY	91.00	0	99,133	9	38.00	
39.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	748	9	39.00	
40.00	HOSPICE	116.00	0	9,263	9	40.00	
41.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	12,199	9	41.00	
42.00	COMMUNITY HEALTH SERVICES	194.00	0	352	9	42.00	
43.00	MARKETING AND PUBLIC RELATIONS	194.02	0	7,977	9	43.00	
44.00	MH RESIDENTIAL	194.03	0	1,651	9	44.00	
45.00	RADIOLOGY-NON-CAMPUS	54.01	0	3,897	9	45.00	
	0		0	10,564,243			
G - INSURANCE EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	558,601	12	1.00	
12.00		0.00	0	0	12	12.00	
	0		0	558,601			

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
H - MENTAL HEALTH OVERHEAD						
1.00	MENTAL HEALTH OVERHEAD	17.01	3,104,420	1,430,127	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
	0		3,104,420	1,430,127		
I - IMPL. DEV. CHARGED TO PATIENT						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	397	0	1.00
2.00	EMERGENCY	91.00	0	6,041	0	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	45	0	3.00
4.00	OPERATING ROOM	50.00	0	1,836,689	0	4.00
5.00	ELECTROCARDIOLOGY	69.00	0	2,395	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	21,790	0	6.00
7.00	ASC (NON-DISTINCT PART)	75.00	0	285,614	0	7.00
	0		0	2,152,971		
J - ONCOLOGY						
1.00	PHARMACY	15.00	515,888	250,268	0	1.00
	0		515,888	250,268		
K - DIETARY						
1.00	DIETARY	10.00	1,013,386	1,095,289	0	1.00
	0		1,013,386	1,095,289		
L - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,076,964	9	1.00
2.00		0.00	0	0	9	2.00
3.00		0.00	0	0	9	3.00
4.00		0.00	0	0	9	4.00
5.00		0.00	0	0	9	5.00
6.00		0.00	0	0	9	6.00
7.00		0.00	0	0	9	7.00
8.00		0.00	0	0	9	8.00
	0		0	7,076,964		
500.00	Grand Total : Decreases		4,633,694	70,947,335		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150042

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

Worksheet A-7
Part I
Date/Time Prepared:
5/25/2016 9:57 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	8,487,647	290,338	0	290,338	1,575,000	1.00
2.00	Land Improvements	6,102,833	3,125,685	0	3,125,685	37,157	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	88,343,615	34,676,819	0	34,676,819	61,624	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	243,795,414	96,389,486	0	96,389,486	93,874,242	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	346,729,509	134,482,328	0	134,482,328	95,548,023	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	346,729,509	134,482,328	0	134,482,328	95,548,023	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,202,985	0				1.00
2.00	Land Improvements	9,191,361	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	122,958,810	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	246,310,658	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	385,663,814	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	385,663,814	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150042

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

Worksheet A-7
Part II
Date/Time Prepared:
5/25/2016 9:57 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	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,065,481	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,065,481	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,065,481				2.00
3.00	Total (sum of lines 1-2)	0	7,065,481				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150042

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

Worksheet A-7
Part III
Date/Time Prepared:
5/25/2016 9:57 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	CAP REL COSTS-BLDG & FIXT	139,353,156	0	139,353,156	0.361333	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	246,310,658	0	246,310,658	0.638667	0	2.00
3.00	Total (sum of lines 1-2)	385,663,814	0	385,663,814	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	17,156,564	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	-11,483	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	17,145,081	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	3,090,599	558,601	0	0	20,805,764	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	-11,483	2.00
3.00	Total (sum of lines 1-2)	3,090,599	558,601	0	0	20,794,281	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150042

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

Worksheet A-8

Date/Time Prepared:
5/25/2016 9:57 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 - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-247,028		PURCHASING & RECEIVING	4.02		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)	B	-217,944		ADMINISTRATIVE & GENERAL	5.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-10,626,563					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	-983,783		CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients	B	-459,939		DRUGS CHARGED TO PATIENTS	73.00		0	17.00
18.00 Sale of medical records and abstracts	B	-61,625		ADMINISTRATIVE & GENERAL	5.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines			0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	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 OTHER MISC FEES	B	-18,273		PURCHASING & RECEIVING	4.02		0	33.00
33.01 OTHER MISC FEES	B	-38,963		PATIENT ACCOUNTS	4.04		0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 150042

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

Worksheet A-8

Date/Time Prepared:
5/25/2016 9:57 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	
33.02 OTHER MISC FEES	B	-314,646	ADMINISTRATIVE & GENERAL		5.00	0 33.02
33.03 RENTAL INCOME	B	-351,116	ADMINISTRATIVE & GENERAL		5.00	0 33.03
33.04 OTHER MISC FEES	B	-2,721	MEDICAL RECORDS & LIBRARY		16.00	0 33.04
33.05 RENTAL INCOME	B	-700	ELECTROCARDIOLOGY		69.00	0 33.05
33.06 OTHER MISC FEES	B	-11	CENTRAL SERVICES & SUPPLY		14.00	0 33.06
33.07 OTHER MISC FEES	B	-5	PHARMACY		15.00	0 33.07
33.08 TRADE, QUANTITY, AND TIME DISCOUNTS	B	-772	OPERATING ROOM		50.00	0 33.08
33.09 TRADE, QUANTITY, AND TIME DISCOUNTS	B	-200	LABORATORY		60.00	0 33.09
33.10 TRADE, QUANTITY, AND TIME DISCOUNTS	B	-16	PHYSICAL THERAPY		66.00	0 33.10
33.11 ANESTHESIOLOGY BENEFITS	B	-344,280	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.11
33.12 RADIOLOGY - SILVER ETC	B	-46	RADIOLOGY-DIAGNOSTIC		54.00	0 33.12
33.13 PT MASSAGE THERAPY	B	-3,157	RESPIRATORY THERAPY		65.00	0 33.13
33.14 FOOD SERVICE	B	-33,886	DIETARY		10.00	0 33.14
33.15 RADIOLOGY - STUDENT TUITION	B	-56,787	PARAMED ED PGRM-(SPECIFY)		23.00	0 33.15
33.16 RENTAL INCOME	B	-19,509	MENTAL HEALTH OVERHEAD		17.01	0 33.16
33.17 RENTAL INCOME	B	-5,750	RADIOLOGY-DIAGNOSTIC		54.00	0 33.17
33.18 PHYSICIAN EMPLOYEE BENEFIT COMPENSAT	A	-26,420	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.18
33.19 PHYSICIAN ON-CALL TIME	A	-148,017	ADMINISTRATIVE & GENERAL		5.00	0 33.19
33.20 AHA USEFUL LIVES CARRYFORWARD	A	-95	CAP REL COSTS-BLDG & FIXT		1.00	9 33.20
33.21 HEALTH PAVILION AHA CARRYFORWARD	A	-26,044	CAP REL COSTS-BLDG & FIXT		1.00	9 33.21
33.22 OTHER MISC FEES	B	-13,125	INTENSIVE CARE UNIT		31.00	0 33.22
33.23 ADVANCE EMT TRAINING	A	-12,750	RESPIRATORY THERAPY		65.00	0 33.23
33.24 1990 ASSETS - AHA LIVES CARRYFORWARD	A	-2,119	CAP REL COSTS-BLDG & FIXT		1.00	9 33.24
33.25 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-130	MEDICAL RECORDS & LIBRARY		16.00	0 33.25
33.26 OTHER MISC FEES	B	-6,840	OPERATION OF PLANT		7.00	0 33.26
33.27 OTHER MISC FEES	B	-31,106	MENTAL HEALTH OVERHEAD		17.01	0 33.27
33.28 INTEREST INCOME	B	-456,385	CAP REL COSTS-BLDG & FIXT		1.00	9 33.28
33.29 OTHER MISC FEES	B	-2,343	RADIOLOGY-DIAGNOSTIC		54.00	0 33.29
33.30 NEPHROLOGY RENTAL INCOME	B	-199,165	INPATIENT DIALYSIS		76.01	0 33.30
33.31 PHYSICIAN BILLING COSTS	A	-192,125	PATIENT ACCOUNTS		4.04	0 33.31
33.32 OTHER MISC FEES	B	-75	LABORATORY		60.00	0 33.32
33.33 OTHER MISC FEES	B	-182	ADULTS & PEDIATRICS		30.00	0 33.33
33.34 OTHER MISC FEES	B	-88	RESPIRATORY THERAPY		65.00	0 33.34
33.35 DONATIONS EXPENSE	A	-50,085	ADMINISTRATIVE & GENERAL		5.00	0 33.35
33.36 OTHER MISC FEES	B	-1,189	PHYSICAL THERAPY		66.00	0 33.36
33.37 2004 SURETY BOND EXPENSE	A	-20,525	ADMINISTRATIVE & GENERAL		5.00	0 33.37
33.38 OTHER MISC FEES	B	-4,522	ELECTROCARDIOLOGY		69.00	0 33.38
33.39 OTHER MISC FEES	B	-1,291	NURSERY		43.00	0 33.39
33.40 OTHER MISC FEES	B	-6,478	OPERATING ROOM		50.00	0 33.40
33.41 OTHER MISC FEES	B	-21	ENDOSCOPY		51.01	0 33.41
33.42 OTHER MISC FEES	B	-56	DELIVERY ROOM & LABOR ROOM		52.00	0 33.42
33.43 2012 BOND ISSUE COSTS	B	45,855	ADMINISTRATIVE & GENERAL		5.00	0 33.43
33.44 IHA LOBBYING OFFSET	B	-3,158	ADMINISTRATIVE & GENERAL		5.00	0 33.44
33.45 OTHER MISC FEES	B	-537	ASC (NON-DI STINCT PART)		75.00	0 33.45
33.46 INDIANA CHAMBER LOBBYING OFFSET	B	-150	ADMINISTRATIVE & GENERAL		5.00	0 33.46
33.47 TRADE, QUANTITY, AND TIME DISCOUNTS	B	-22,279	ADMINISTRATIVE & GENERAL		5.00	0 33.47
33.48 TRADE, QUANTITY, AND TIME DISCOUNTS	B	-1,057	OPERATION OF PLANT		7.00	0 33.48
33.49 TRADE, QUANTITY, AND TIME DISCOUNTS	B	-16	MENTAL HEALTH OVERHEAD		17.01	0 33.49
33.50 OTHER MISC FEES	B	-1,790	CLINIC		90.00	0 33.50
33.51 TRADE, QUANTITY, AND TIME DISCOUNTS	B	-2	SUBPROVIDER - IRF		41.00	0 33.51
33.52 OTHER MISC FEES	B	-7,875	EMERGENCY		91.00	0 33.52
33.53 ADVERTISING	A	-4,082	ADMINISTRATIVE & GENERAL		5.00	0 33.53
33.54 ADVERTISING	A	-592	RADIOLOGY-DIAGNOSTIC		54.00	0 33.54
33.55 ADVERTISING	A	-145	PHYSICAL THERAPY		66.00	0 33.55
33.56 ADVERTISING	A	-125	HOSPICE		116.00	0 33.56
33.57 BEAUTY SHOP EXPENSE	A	-840	ADMINISTRATIVE & GENERAL		5.00	0 33.57
33.58 ALCOHOLIC BEVERAGES	A	-1,039	ADMINISTRATIVE & GENERAL		5.00	0 33.58
33.59 HAF ADJUSTMENT	A	-4,312,793	ADMINISTRATIVE & GENERAL		5.00	0 33.59

Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8 Date/Time Prepared: 5/25/2016 9:57 am
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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	4.00	5.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-19,299,521			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: 150042

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

Worksheet A-8-2

Date/Time Prepared:
5/25/2016 9:57 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	17.01	MENTAL HEALTH OVERHEAD	724,995	540,435	184,560	159,800	1,828	1.00
2.00	50.00	OPERATING ROOM	1,476,100	1,476,100	0	0	0	2.00
3.00	54.00	DR. O	253,224	212,074	41,150	159,800	1,580	3.00
4.00	54.08	DR. G	197,154	142,154	55,000	217,600	520	4.00
5.00	60.00	DR. Q	124,608	61,094	63,514	159,800	1,337	5.00
6.00	65.00	DR. R	18,000	0	18,000	159,800	300	6.00
7.00	69.00	ELECTROCARDIOLOGY	2,130,662	2,120,932	9,730	159,800	31	7.00
8.00	70.01	NEURODIAGNOSTICS	19,500	0	19,500	159,800	80	8.00
9.00	76.01	DR. S	40,000	0	40,000	159,800	336	9.00
10.00	75.00	ASC (NON-DISTINCT PART)	11,001	-1,000	12,001	159,800	144	10.00
11.00	90.00	DR. L	819,734	792,113	27,621	159,800	144	11.00
12.00	91.00	EMERGENCY	5,216,595	5,149,232	67,363	159,800	404	12.00
200.00			11,031,573	10,493,134	538,439		6,704	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	17.01	MENTAL HEALTH OVERHEAD	140,440	7,022	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	DR. O	121,386	6,069	0	0	0	3.00
4.00	54.08	DR. G	54,400	2,720	0	0	0	4.00
5.00	60.00	DR. Q	102,718	5,136	0	0	0	5.00
6.00	65.00	DR. R	23,048	1,152	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	2,382	119	0	0	0	7.00
8.00	70.01	NEURODIAGNOSTICS	6,146	307	0	0	0	8.00
9.00	76.01	DR. S	25,814	1,291	0	0	0	9.00
10.00	75.00	ASC (NON-DISTINCT PART)	11,063	553	0	0	0	10.00
11.00	90.00	DR. L	11,063	553	0	0	0	11.00
12.00	91.00	EMERGENCY	31,038	1,552	0	0	0	12.00
200.00			529,498	26,474	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	17.01	MENTAL HEALTH OVERHEAD	0	140,440	44,120	584,555	1.00
2.00	50.00	OPERATING ROOM	0	0	0	1,476,100	2.00
3.00	54.00	DR. O	0	121,386	0	212,074	3.00
4.00	54.08	DR. G	0	54,400	600	142,754	4.00
5.00	60.00	DR. Q	0	102,718	0	61,094	5.00
6.00	65.00	DR. R	0	23,048	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	2,382	7,348	2,128,280	7.00
8.00	70.01	NEURODIAGNOSTICS	0	6,146	13,354	13,354	8.00
9.00	76.01	DR. S	0	25,814	14,186	14,186	9.00
10.00	75.00	ASC (NON-DISTINCT PART)	0	11,063	938	-62	10.00
11.00	90.00	DR. L	0	11,063	16,558	808,671	11.00
12.00	91.00	EMERGENCY	0	31,038	36,325	5,185,557	12.00
200.00			0	529,498	133,429	10,626,563	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150042

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

Worksheet B
Part I
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	20,805,764	20,805,764			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	-11,483		-11,483		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	23,882,960	105,865	0	23,988,825	4.00
4.01 00401	COMMUNICATIONS	265,892	0	0	61,484	327,376 4.01
4.02 00402	PURCHASING & RECEIVING	467,547	363,732	0	164,184	3,458 4.02
4.03 00403	REGISTRATION	914,402	0	0	199,049	3,170 4.03
4.04 00404	PATIENT ACCOUNTS	3,953,950	0	0	492,217	14,697 4.04
5.00 00500	ADMINISTRATIVE & GENERAL	18,916,194	1,108,083	0	2,028,783	32,565 5.00
7.00 00700	OPERATION OF PLANT	6,099,614	3,384,050	0	585,789	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	358,583	126,672	0	48,858	0 8.00
9.00 00900	HOUSEKEEPING	2,286,261	185,727	0	476,279	2,738 9.00
10.00 01000	DIETARY	643,273	0	0	77,328	2,594 10.00
11.00 01100	CAFETERIA	1,124,892	300,973	0	250,211	144 11.00
13.00 01300	NURSING ADMINISTRATION	1,953,654	250,867	0	394,198	5,331 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	548,432	6,182	0	87,996	1,153 14.00
15.00 01500	PHARMACY	3,081,293	148,875	0	671,068	6,052 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,421,705	117,339	0	602,549	11,671 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
17.01 01701	MENTAL HEALTH OVERHEAD	1,745,857	82,797	0	394,863	18,444 17.01
23.00 02300	PARAMED PGRM-(SPECIFY)	167,782	0	0	47,072	0 23.00
23.01 02302	PARAMED PGRM-(SPECIFY)	14,602	0	0	2,983	0 23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,601,916	1,821,788	0	1,401,501	66,716 30.00
31.00 03100	INTENSIVE CARE UNIT	3,988,989	643,152	0	855,856	5,475 31.00
40.00 04000	SUBPROVIDER - I/PF	755,757	318,798	0	127,750	865 40.00
41.00 04100	SUBPROVIDER - I/RF	3,734,348	533,511	0	668,960	10,951 41.00
43.00 04300	NURSERY	383,748	0	0	81,866	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	4,042,455	454,755	0	898,203	10,951 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
51.01 05101	ENDOSCOPY	1,309,263	294,358	0	235,643	3,314 51.01
52.00 05200	DELIVERY ROOM & LABOR ROOM	502,922	0	0	108,296	0 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	6,000,710	562,376	0	940,711	14,841 54.00
54.01 05401	RADIOLOGY-NON-CAMPUS	1,177,646	115,872	0	196,875	0 54.01
54.08 05408	RADIOLOGY-GSH BREAST CENTER	198,793	0	0	66,300	0 54.08
60.00 06000	LABORATORY	4,224,733	199,847	0	602,146	6,772 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	834,139	0	0	0	0 63.00
65.00 06500	RESPIRATORY THERAPY	2,183,153	133,672	0	472,571	4,035 65.00
66.00 06600	PHYSICAL THERAPY	2,847,009	199,390	0	615,389	720 66.00
69.00 06900	ELECTROCARDIOLOGY	2,967,939	387,570	0	1,065,787	6,340 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
70.01 07001	NEURODIAGNOSTICS	373,376	183,899	0	78,570	3,314 70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,884,046	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	2,152,971	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	14,106,335	0	0	131,654	0 73.00
75.00 07500	ASC (NON-DISTINCT PART)	2,064,114	0	0	236,294	9,222 75.00
76.00 03020	MH ANCILLARY OUTPATIENT	0	0	0	0	0 76.00
76.01 03950	INPATIENT DIAGNOSIS	460,431	206,438	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	1,253,139	64,178	0	392,578	0 90.00
91.00 09100	EMERGENCY	4,156,425	397,361	0	867,319	6,916 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	121,934	9,478	0	15,757	0 96.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	1,175,234	116,930	0	156,592	432 116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	168,142,699	12,824,535	0	16,801,529	252,881 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	33,892,642	3,271,810	0	6,510,037	66,138 192.00
194.00 07950	COMMUNITY HEALTH SERVICES	240,616	61,003	0	37,241	5,331 194.00
194.02 07952	MARKETING AND PUBLIC RELATIONS	1,087,044	21,048	0	41,803	0 194.02
194.03 07953	MH RESIDENTIAL	463,741	487,350	0	95,046	0 194.03
194.04 07954	UNUSED SPACE	0	2,634,719	0	0	0 194.04
194.05 07955	MOB	260,721	586,287	0	51,759	432 194.05
194.06 07956	FOUNDATION	1,208,390	15,828	0	28,930	0 194.06

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150042

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

Worksheet B
Part I
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4.01	
194.07 07957 KNOX COUNTY HEALTH DEPT	0	113,346	0	0	2,594	194.07
194.08 07958 INDUSTRIAL HEALTH	20,757	0	0	4,389	0	194.08
194.09 07959 NRCC	2,473,389	789,838	0	418,091	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	-11,483	0	0	201.00
202.00 TOTAL (sum lines 118-201)	207,789,999	20,805,764	-11,483	23,988,825	327,376	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150042

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

Worksheet B
Part I
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description			PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL	
			4.02	4.03	4.04	4A.04	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING	998,921					4.02
4.03	00403	REGISTRATION	639	1,117,260				4.03
4.04	00404	PATIENT ACCOUNTS	2,269	0	4,463,133			4.04
5.00	00500	ADMINISTRATIVE & GENERAL	7,260	0	0	22,092,885	22,092,885	5.00
7.00	00700	OPERATION OF PLANT	8,871	0	0	10,078,324	1,198,968	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,363	0	0	536,476	63,822	8.00
9.00	00900	HOUSEKEEPING	6,500	0	0	2,957,505	351,840	9.00
10.00	01000	DIETARY	36,308	0	0	759,503	90,354	10.00
11.00	01100	CAFETERIA	0	0	0	1,676,220	199,412	11.00
13.00	01300	NURSING ADMINISTRATION	681	0	0	2,604,731	309,872	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,897	0	0	646,660	76,930	14.00
15.00	01500	PHARMACY	427,593	0	0	4,334,881	515,699	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	431	0	0	4,153,695	494,144	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	5,543	0	0	2,247,504	267,374	17.01
23.00	02300	PARAMED ED PGRM-(SPECIFY)	7	0	0	214,861	25,561	23.00
23.01	02302	PARAMED ED PGRM-(SPECIFY)	42	0	0	17,627	2,097	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	47,131	67,868	271,150	11,278,070	1,341,696	30.00
31.00	03100	INTENSIVE CARE UNIT	8,768	34,805	139,055	5,676,100	675,257	31.00
40.00	04000	SUBPROVIDER - I/PF	0	11,711	46,787	1,261,668	150,094	40.00
41.00	04100	SUBPROVIDER - I/RF	3,130	17,735	70,855	5,039,490	599,523	41.00
43.00	04300	NURSERY	1,044	2,578	10,300	479,536	57,048	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	45,436	63,089	252,055	5,766,944	686,064	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	13,919	29,369	117,337	2,003,203	238,311	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,919	9,236	36,902	659,275	78,431	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,077	182,102	726,949	8,459,766	1,006,416	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	3,987	40,875	163,307	1,698,562	202,069	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	388	1,026	4,101	270,608	32,193	54.08
60.00	06000	LABORATORY	82,296	112,826	450,767	5,679,387	675,648	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	8,286	33,105	875,530	104,157	63.00
65.00	06500	RESPIRATORY THERAPY	7,875	29,303	117,072	2,947,681	350,671	65.00
66.00	06600	PHYSICAL THERAPY	2,427	67,148	268,272	4,000,355	475,902	66.00
69.00	06900	ELECTROCARDIOLOGY	33,180	76,452	305,444	4,842,712	576,113	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	813	13,391	53,500	706,863	84,092	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	21,013	83,953	8,989,012	1,069,378	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,859	27,238	108,821	2,354,889	280,149	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	138,352	552,751	14,929,092	1,776,039	73.00
75.00	07500	ASC (NON-DISTINCT PART)	43,608	53,552	213,952	2,620,742	311,777	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	180	3,016	12,048	682,113	81,148	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	13,808	9,786	39,096	1,772,585	210,876	90.00
91.00	09100	EMERGENCY	8,997	88,048	351,774	5,876,840	699,138	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,780	1,463	5,844	157,256	18,708	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	737	6,992	27,936	1,484,853	176,646	116.00
118.00	11800	SUBTOTALS (SUM OF LINES 1-117)	921,763	1,117,260	4,463,133	152,834,004	15,553,617	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	51,306	0	0	43,791,933	5,209,770	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	914	0	0	345,105	41,055	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	20,052	0	0	1,169,947	139,183	194.02
194.03	07953	MH RESIDENTIAL	1,430	0	0	1,047,567	124,624	194.03
194.04	07954	UNUSED SPACE	0	0	0	2,634,719	313,439	194.04
194.05	07955	MOB	263	0	0	899,462	107,004	194.05
194.06	07956	FOUNDATION	3,188	0	0	1,256,336	149,460	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	115,940	13,793	194.07
194.08	07958	INDUSTRIAL HEALTH	5	0	0	25,151	2,992	194.08
194.09	07959	NRCC	0	0	0	3,681,318	437,948	194.09
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	-11,483	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part I Date/Time Prepared: 5/25/2016 9:57 am
Cost Center Description		PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL
202.00	TOTAL (sum lines 118-201)	998,921	1,117,260	4,463,133	207,789,999	22,092,885

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part I Date/Time Prepared: 5/25/2016 9:57 am				
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
4.01	00401	COMMUNICATIONS					4.01	
4.02	00402	PURCHASING & RECEIVING					4.02	
4.03	00403	REGISTRATION					4.03	
4.04	00404	PATIENT ACCOUNTS					4.04	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	11,277,292				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	90,161	690,459			8.00	
9.00	00900	HOUSEKEEPING	132,195	37,729	3,479,269		9.00	
10.00	01000	DIETARY	0	10,189	106,382	966,428	10.00	
11.00	01100	CAFETERIA	214,223	0	22,542	0	2,112,397	11.00
13.00	01300	NURSING ADMINISTRATION	178,559	0	0	0	34,003	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,400	1,652	43,463	0	22,126	14.00
15.00	01500	PHARMACY	105,965	0	33,316	0	77,416	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	83,518	0	19,404	0	106,130	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	58,932	11,492	96,549	0	148,597	17.01
23.00	02300	PARAMED ED PGRM-(SPECIFY)	0	0	0	0	5,335	23.00
23.01	02302	PARAMED ED PGRM-(SPECIFY)	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,296,692	226,161	937,300	433,902	226,473	30.00
31.00	03100	INTENSIVE CARE UNIT	457,776	91,331	295,923	179,321	117,096	31.00
40.00	04000	SUBPROVIDER - I/PF	226,910	0	0	111,883	52,246	40.00
41.00	04100	SUBPROVIDER - I/RF	379,736	46,976	177,146	213,451	109,182	41.00
43.00	04300	NURSERY	0	5,996	10,617	27,871	10,073	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	323,681	28,213	258,632	0	49,881	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	209,515	17,681	53,975	0	28,664	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,924	12,657	0	12,961	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	400,282	56,411	170,451	0	116,963	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	82,474	0	0	0	22,356	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0	0	0	0	0	54.08
60.00	06000	LABORATORY	142,245	0	53,923	0	98,226	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	95,144	102	39,488	0	58,718	65.00
66.00	06600	PHYSICAL THERAPY	141,920	24,569	73,955	0	64,330	66.00
69.00	06900	ELECTROCARDIOLOGY	275,861	11,857	103,348	0	73,439	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	130,893	11,423	65,325	0	12,349	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	25,893	167,418	0	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	146,936	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	45,680	17	23,222	0	27,285	90.00
91.00	09100	EMERGENCY	282,829	58,472	163,286	0	119,220	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	6,746	0	0	0	2,761	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	83,227	0	60,827	0	21,172	116.00
118.00	11800	SUBTOTALS (SUM OF LINES 1-117)	5,596,500	672,088	2,989,149	966,428	1,617,002	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,328,775	18,371	447,964	0	444,864	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	43,420	0	14,749	0	6,366	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	14,981	0	6,329	0	7,108	194.02
194.03	07953	MH RESIDENTIAL	346,880	0	0	0	26,010	194.03
194.04	07954	UNUSED SPACE	1,875,311	0	0	0	0	194.04
194.05	07955	MOB	417,301	0	0	0	7,552	194.05
194.06	07956	FOUNDATION	11,266	0	0	0	3,495	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	80,676	0	21,078	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	NRCC	562,182	0	0	0	0	194.09
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150042

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

Worksheet B
Part I
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	7.00	8.00	9.00	10.00	11.00	
202.00 TOTAL (sum lines 118-201)	11,277,292	690,459	3,479,269	966,428	2,112,397	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150042

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

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Part I
Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	3,127,165					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	795,231				14.00
15.00	01500	PHARMACY	0	365,188	5,432,465			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	368	0	4,857,259		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	0	4,734	556	0	0	17.01
23.00	02300	PARAMED ED PGRM-(SPECIFY)	0	6	0	0	0	23.00
23.01	02302	PARAMED ED PGRM-(SPECIFY)	0	36	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	985,961	40,251	5,190	2,225,397	0	30.00
31.00	03100	INTENSIVE CARE UNIT	509,780	7,488	3,719	951,806	0	31.00
40.00	04000	SUBPROVIDER - I/PF	227,454	0	0	172,748	0	40.00
41.00	04100	SUBPROVIDER - I/RF	475,330	2,673	2,669	203,233	0	41.00
43.00	04300	NURSERY	43,854	891	146	37,259	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	217,159	38,804	22,043	169,360	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	11,887	869	142,263	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,428	1,639	247	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	27,395	41,927	0	0	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0	3,405	11,667	0	0	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0	332	0	0	0	54.08
60.00	06000	LABORATORY	0	70,284	1,144	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	6,726	1,265	13,549	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,073	6,512	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	28,337	479	111,778	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	695	9	47,421	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	56,246	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,805,908	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	37,243	33,274	210,007	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	154	962	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	11,792	4,103	0	0	90.00
91.00	09100	EMERGENCY	519,028	7,684	3,877	572,438	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	2,375	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	92,171	629	8	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,127,165	729,335	4,946,574	4,857,259	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	43,817	479,272	0	0	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	781	6,619	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	17,125	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	1,221	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	225	0	0	0	194.05
194.06	07956	FOUNDATION	0	2,723	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	4	0	0	0	194.08
194.09	07959	NRCC	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150042

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

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Cost Center Description		NURSING	CENTRAL	PHARMACY	MEDICAL	SOCIAL SERVICE	
		ADMINISTRATION	SERVICES & SUPPLY		RECORDS & LIBRARY		
		13.00	14.00	15.00	16.00	17.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	3,127,165	795,231	5,432,465	4,857,259	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150042

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

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Part I
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Cost Center Description			MENTAL HEALTH OVERHEAD	PARAMED ED PGRM	PARAMED ED PGRM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			17.01	23.00	23.01	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	MENTAL HEALTH OVERHEAD	2,835,738					17.01
23.00	02300	PARAMED ED PGRM-(SPECIFY)	0	245,763				23.00
23.01	02302	PARAMED ED PGRM-(SPECIFY)	0		19,760			23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,002,443	0	0	19,999,536	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	8,965,597	0	31.00
40.00	04000	SUBPROVIDER - I/PF	277,804	0	0	2,480,807	0	40.00
41.00	04100	SUBPROVIDER - I/RF	0	0	0	7,249,409	0	41.00
43.00	04300	NURSERY	0	0	0	673,291	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	7,560,781	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	2,706,368	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	827,562	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	245,763	0	10,525,374	0	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0	0	0	2,020,533	0	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0	0	0	303,133	0	54.08
60.00	06000	LABORATORY	0	0	19,760	6,740,617	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	979,687	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,513,344	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,789,616	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,023,924	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	1,059,070	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	10,058,390	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,691,284	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,511,039	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,270,403	0	0	4,676,757	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	0	0	911,313	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,095,560	0	90.00
91.00	09100	EMERGENCY	0	0	0	8,302,812	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	187,846	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	1,919,533	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,550,650	245,763	19,760	138,773,183	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	285,088	0	0	53,049,854	0	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	458,095	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	1,354,673	0	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	1,546,302	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	4,823,469	0	194.04
194.05	07955	MOB	0	0	0	1,431,544	0	194.05
194.06	07956	FOUNDATION	0	0	0	1,423,280	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	231,487	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	28,147	0	194.08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150042

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

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Cost Center Description			MENTAL HEALTH OVERHEAD	PARAMED ED PGRM	PARAMED ED PGRM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			17.01	23.00	23.01	24.00	25.00	
194.09	07959	NRCC	0	0	0	4,681,448	0	194.09
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	-11,483	0	201.00
202.00		TOTAL (sum lines 118-201)	2,835,738	245,763	19,760	207,789,999	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150042

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

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
4.01	00401	COMMUNICATIONS	4.01
4.02	00402	PURCHASING & RECEIVING	4.02
4.03	00403	REGISTRATION	4.03
4.04	00404	PATIENT ACCOUNTS	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	17.01
23.00	02300	PARAMED PGRM-(SPECIFY)	23.00
23.01	02302	PARAMED PGRM-(SPECIFY)	23.01
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
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
51.01	05101	ENDOSCOPY	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	54.08
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
70.01	07001	NEURODIAGNOSTICS	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	76.00
76.01	03950	INPATIENT DIALYSIS	76.01
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	96.00
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	194.02
194.03	07953	MH RESIDENTIAL	194.03
194.04	07954	UNUSED SPACE	194.04
194.05	07955	MOB	194.05
194.06	07956	FOUNDATION	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	194.07
194.08	07958	INDUSTRIAL HEALTH	194.08
194.09	07959	NRCC	194.09
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150042

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

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	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
			0	1.00			
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400	0	105,865	0	105,865	105,865	4.00
4.01	00401	0	0	0	0	271	4.01
4.02	00402	0	363,732	0	363,732	725	4.02
4.03	00403	0	0	0	0	879	4.03
4.04	00404	0	0	0	0	2,173	4.04
5.00	00500	0	1,108,083	0	1,108,083	8,956	5.00
7.00	00700	0	3,384,050	0	3,384,050	2,586	7.00
8.00	00800	0	126,672	0	126,672	216	8.00
9.00	00900	0	185,727	0	185,727	2,103	9.00
10.00	01000	0	0	0	0	341	10.00
11.00	01100	0	300,973	0	300,973	1,105	11.00
13.00	01300	0	250,867	0	250,867	1,740	13.00
14.00	01400	0	6,182	0	6,182	388	14.00
15.00	01500	0	148,875	0	148,875	2,963	15.00
16.00	01600	0	117,339	0	117,339	2,660	16.00
17.00	01700	0	0	0	0	0	17.00
17.01	01701	0	82,797	0	82,797	1,743	17.01
23.00	02300	0	0	0	0	208	23.00
23.01	02302	0	0	0	0	13	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	1,821,788	0	1,821,788	6,187	30.00
31.00	03100	0	643,152	0	643,152	3,778	31.00
40.00	04000	0	318,798	0	318,798	564	40.00
41.00	04100	0	533,511	0	533,511	2,953	41.00
43.00	04300	0	0	0	0	361	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	454,755	0	454,755	3,965	50.00
51.00	05100	0	0	0	0	0	51.00
51.01	05101	0	294,358	0	294,358	1,040	51.01
52.00	05200	0	0	0	0	478	52.00
54.00	05400	0	562,376	0	562,376	4,153	54.00
54.01	05401	0	115,872	0	115,872	869	54.01
54.08	05408	0	0	0	0	293	54.08
60.00	06000	0	199,847	0	199,847	2,658	60.00
63.00	06300	0	0	0	0	0	63.00
65.00	06500	0	133,672	0	133,672	2,086	65.00
66.00	06600	0	199,390	0	199,390	2,717	66.00
69.00	06900	0	387,570	0	387,570	4,705	69.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	0	183,899	0	183,899	347	70.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	581	73.00
75.00	07500	0	0	0	0	1,043	75.00
76.00	03020	0	0	0	0	0	76.00
76.01	03950	0	206,438	0	206,438	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	64,178	0	64,178	1,733	90.00
91.00	09100	0	397,361	0	397,361	3,829	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	0	9,478	0	9,478	70	96.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
116.00	11600	0	116,930	0	116,930	691	116.00
118.00		0	12,824,535	0	12,824,535	74,171	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	3,271,810	0	3,271,810	28,704	192.00
194.00	07950	0	61,003	0	61,003	164	194.00
194.02	07952	0	21,048	0	21,048	185	194.02
194.03	07953	0	487,350	0	487,350	420	194.03
194.04	07954	0	2,634,719	0	2,634,719	0	194.04
194.05	07955	0	586,287	0	586,287	228	194.05
194.06	07956	0	15,828	0	15,828	128	194.06
194.07	07957	0	113,346	0	113,346	0	194.07

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150042

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

Worksheet B
Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
	0			2A	4.00	
194.08 07958 INDUSTRIAL HEALTH	0	0	0	0	19	194.08
194.09 07959 NRCC	0	789,838	0	789,838	1,846	194.09
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	-11,483	-11,483	0	201.00
202.00 TOTAL (sum lines 118-201)	0	20,805,764	-11,483	20,794,281	105,865	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/25/2016 9:57 am				
Cost Center Description		COMMUNICATIONS 4.01	PURCHASING & RECEIVING 4.02	REGISTRATION 4.03	PATIENT ACCOUNTS 4.04	ADMINISTRATIVE & GENERAL 5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00		
4.01	00401	COMMUNICATIONS	271			4.01		
4.02	00402	PURCHASING & RECEIVING	3	364,460		4.02		
4.03	00403	REGISTRATION	3	233	1,115	4.03		
4.04	00404	PATIENT ACCOUNTS	12	828	0	3,013	4.04	
5.00	00500	ADMINISTRATIVE & GENERAL	27	2,649	0	0	1,119,715	5.00
7.00	00700	OPERATION OF PLANT	0	3,236	0	0	60,762	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	862	0	0	3,234	8.00
9.00	00900	HOUSEKEEPING	2	2,372	0	0	17,831	9.00
10.00	01000	DIETARY	2	13,247	0	0	4,579	10.00
11.00	01100	CAFETERIA	0	0	0	0	10,106	11.00
13.00	01300	NURSING ADMINISTRATION	4	249	0	0	15,704	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1	1,057	0	0	3,899	14.00
15.00	01500	PHARMACY	5	156,004	0	0	26,135	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10	157	0	0	25,043	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	15	2,022	0	0	13,550	17.01
23.00	02300	PARAMED ED PGRM-(SPECIFY)	0	3	0	0	1,295	23.00
23.01	02302	PARAMED ED PGRM-(SPECIFY)	0	15	0	0	106	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	55	17,196	59	176	67,995	30.00
31.00	03100	INTENSIVE CARE UNIT	5	3,199	30	90	34,221	31.00
40.00	04000	SUBPROVIDER - I/PF	1	0	10	30	7,607	40.00
41.00	04100	SUBPROVIDER - I/RF	9	1,142	15	46	30,383	41.00
43.00	04300	NURSERY	0	381	2	7	2,891	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9	16,578	55	164	34,769	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	3	5,078	25	76	12,077	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	700	8	24	3,975	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12	11,704	307	587	51,004	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0	1,455	35	106	10,241	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0	142	1	3	1,631	54.08
60.00	06000	LABORATORY	6	30,027	98	293	34,241	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	7	21	5,279	63.00
65.00	06500	RESPIRATORY THERAPY	3	2,873	25	76	17,772	65.00
66.00	06600	PHYSICAL THERAPY	1	886	58	174	24,118	66.00
69.00	06900	ELECTROCARDIOLOGY	5	12,106	66	198	29,197	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	3	297	12	35	4,262	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	18	55	54,195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	24,029	24	71	14,198	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	120	359	90,007	73.00
75.00	07500	ASC (NON-DISTINCT PART)	8	15,911	46	139	15,800	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	66	3	8	4,112	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	5,038	8	25	10,687	90.00
91.00	09100	EMERGENCY	6	3,283	76	228	35,431	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	1,014	1	4	948	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	269	6	18	8,952	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	210	336,308	1,115	3,013	788,237	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	55	18,719	0	0	264,099	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	4	334	0	0	2,081	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	7,316	0	0	7,054	194.02
194.03	07953	MH RESIDENTIAL	0	522	0	0	6,316	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	15,885	194.04
194.05	07955	MOB	0	96	0	0	5,423	194.05
194.06	07956	FOUNDATION	0	1,163	0	0	7,574	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	2	0	0	0	699	194.07
194.08	07958	INDUSTRIAL HEALTH	0	2	0	0	152	194.08
194.09	07959	NRCC	0	0	0	0	22,195	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150042			Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/25/2016 9:57 am
Cost Center Description		COMMUNICATIONS	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	ADMINISTRATIVE & GENERAL
202.00	TOTAL (sum lines 118-201)	271	364,460	1,115	3,013	1,119,715

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/25/2016 9:57 am				
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
4.01	00401	COMMUNICATIONS					4.01	
4.02	00402	PURCHASING & RECEIVING					4.02	
4.03	00403	REGISTRATION					4.03	
4.04	00404	PATIENT ACCOUNTS					4.04	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	3,450,634				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	27,588	158,572			8.00	
9.00	00900	HOUSEKEEPING	40,449	8,665	257,149		9.00	
10.00	01000	DIETARY	0	2,340	7,863	28,372	10.00	
11.00	01100	CAFETERIA	65,548	0	1,666	0	379,398	11.00
13.00	01300	NURSING ADMINISTRATION	54,636	0	0	0	6,107	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,346	379	3,212	0	3,974	14.00
15.00	01500	PHARMACY	32,423	0	2,462	0	13,904	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,555	0	1,434	0	19,062	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	18,032	2,639	7,136	0	26,689	17.01
23.00	02300	PARAMED ED PGRM-(SPECIFY)	0	0	0	0	958	23.00
23.01	02302	PARAMED ED PGRM-(SPECIFY)	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	396,763	51,943	69,275	12,739	40,676	30.00
31.00	03100	INTENSIVE CARE UNIT	140,071	20,975	21,871	5,264	21,031	31.00
40.00	04000	SUBPROVIDER - I/PF	69,430	0	0	3,285	9,384	40.00
41.00	04100	SUBPROVIDER - I/RF	116,192	10,788	13,093	6,266	19,610	41.00
43.00	04300	NURSERY	0	1,377	785	818	1,809	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	99,040	6,480	19,115	0	8,959	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	64,108	4,061	3,989	0	5,148	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,360	935	0	2,328	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	122,479	12,955	12,598	0	21,007	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	25,235	0	0	0	4,015	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0	0	0	0	0	54.08
60.00	06000	LABORATORY	43,524	0	3,985	0	17,642	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	29,112	23	2,919	0	10,546	65.00
66.00	06600	PHYSICAL THERAPY	43,425	5,642	5,466	0	11,554	66.00
69.00	06900	ELECTROCARDIOLOGY	84,408	2,723	7,638	0	13,190	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	40,051	2,623	4,828	0	2,218	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	5,947	12,374	0	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	44,960	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	13,977	4	1,716	0	4,901	90.00
91.00	09100	EMERGENCY	86,540	13,429	12,068	0	21,413	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,064	0	0	0	496	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	25,466	0	4,496	0	3,803	116.00
118.00	11800	SUBTOTALS (SUM OF LINES 1-117)	1,712,422	154,353	220,924	28,372	290,424	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	712,559	4,219	33,109	0	79,898	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	13,286	0	1,090	0	1,143	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	4,584	0	468	0	1,277	194.02
194.03	07953	MH RESIDENTIAL	106,139	0	0	0	4,672	194.03
194.04	07954	UNUSED SPACE	573,809	0	0	0	0	194.04
194.05	07955	MOB	127,686	0	0	0	1,356	194.05
194.06	07956	FOUNDATION	3,447	0	0	0	628	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	24,685	0	1,558	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	NRCC	172,017	0	0	0	0	194.09
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150042			Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 5/25/2016 9:57 am	
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
202.00	TOTAL (sum lines 118-201)	3,450,634	158,572	257,149	28,372	379,398	202.00	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150042

Period:
From 01/01/2015
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
4.01	00401						4.01
4.02	00402						4.02
4.03	00403						4.03
4.04	00404						4.04
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	329,307					13.00
14.00	01400	0	20,438				14.00
15.00	01500	0	9,392	392,163			15.00
16.00	01600	0	9	0	191,269		16.00
17.00	01700	0	0	0	0	0	17.00
17.01	01701	0	122	40	0	0	17.01
23.00	02300	0	0	0	0	0	23.00
23.01	02302	0	1	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	103,827	1,034	375	87,632	0	30.00
31.00	03100	53,683	192	268	37,480	0	31.00
40.00	04000	23,952	0	0	6,802	0	40.00
41.00	04100	50,055	69	193	8,003	0	41.00
43.00	04300	4,618	23	11	1,467	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	22,868	997	1,591	6,669	0	50.00
51.00	05100	0	0	0	0	0	51.00
51.01	05101	0	305	63	5,602	0	51.01
52.00	05200	5,942	42	18	0	0	52.00
54.00	05400	0	704	3,027	0	0	54.00
54.01	05401	0	87	842	0	0	54.01
54.08	05408	0	9	0	0	0	54.08
60.00	06000	0	1,805	83	0	0	60.00
63.00	06300	0	0	0	0	0	63.00
65.00	06500	0	173	91	534	0	65.00
66.00	06600	0	53	470	0	0	66.00
69.00	06900	0	728	35	4,402	0	69.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	0	18	1	1,867	0	70.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	1,445	0	0	0	72.00
73.00	07300	0	0	346,931	0	0	73.00
75.00	07500	0	957	2,402	8,270	0	75.00
76.00	03020	0	0	0	0	0	76.00
76.01	03950	0	4	69	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	303	296	0	0	90.00
91.00	09100	54,656	197	280	22,541	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	0	61	0	0	0	96.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	9,706	16	1	0	0	116.00
118.00		329,307	18,746	357,087	191,269	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	1,125	34,598	0	0	192.00
194.00	07950	0	20	478	0	0	194.00
194.02	07952	0	440	0	0	0	194.02
194.03	07953	0	31	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	6	0	0	0	194.05
194.06	07956	0	70	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
200.00							200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150042

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Cost Center Description		NURSING	CENTRAL	PHARMACY	MEDICAL	SOCIAL SERVICE	
		ADMINISTRATION	SERVICES & SUPPLY		RECORDS & LIBRARY		
		13.00	14.00	15.00	16.00	17.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	329,307	20,438	392,163	191,269	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/25/2016 9:57 am	
Cost Center Description	MENTAL HEALTH OVERHEAD	PARAMED PGRM	PARAMED PGRM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	17.01	23.00	23.01	24.00	25.00
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
4.01 00401	COMMUNICATIONS				4.01
4.02 00402	PURCHASING & RECEIVING				4.02
4.03 00403	REGISTRATION				4.03
4.04 00404	PATIENT ACCOUNTS				4.04
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
17.01 01701	MENTAL HEALTH OVERHEAD	154,785			17.01
23.00 02300	PARAMED PGRM-(SPECIFY)	0	2,464		23.00
23.01 02302	PARAMED PGRM-(SPECIFY)	0		135	23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	54,717		2,732,437	30.00
31.00 03100	INTENSIVE CARE UNIT	0		985,310	31.00
40.00 04000	SUBPROVIDER - I/PF	15,164		455,027	40.00
41.00 04100	SUBPROVIDER - I/RF	0		792,328	41.00
43.00 04300	NURSERY	0		14,550	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0		676,014	50.00
51.00 05100	RECOVERY ROOM	0		0	51.00
51.01 05101	ENDOSCOPY	0		395,933	51.01
52.00 05200	DELIVERY ROOM & LABOR ROOM	0		15,810	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0		802,913	54.00
54.01 05401	RADIOLOGY-NON-CAMPUS	0		158,757	54.01
54.08 05408	RADIOLOGY-GSH BREAST CENTER	0		2,079	54.08
60.00 06000	LABORATORY	0		334,209	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0		5,307	63.00
65.00 06500	RESPIRATORY THERAPY	0		199,905	65.00
66.00 06600	PHYSICAL THERAPY	0		293,954	66.00
69.00 06900	ELECTROCARDIOLOGY	0		546,971	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0		0	70.00
70.01 07001	NEURODIAGNOSTICS	0		240,461	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		54,268	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0		39,767	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0		437,998	73.00
75.00 07500	ASC (NON-DISTINCT PART)	69,343		132,240	75.00
76.00 03020	MH ANCILLARY OUTPATIENT	0		0	76.00
76.01 03950	INPATIENT DIALYSIS	0		255,660	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	0		102,866	90.00
91.00 09100	EMERGENCY	0		651,338	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0		14,136	96.00
101.00 10100	HOME HEALTH AGENCY	0		0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE	0		0	113.00
116.00 11600	HOSPICE	0		170,354	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	139,224	0	10,510,592	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	15,561		4,464,456	192.00
194.00 07950	COMMUNITY HEALTH SERVICES	0		79,603	194.00
194.02 07952	MARKETING AND PUBLIC RELATIONS	0		42,372	194.02
194.03 07953	MH RESIDENTIAL	0		605,450	194.03
194.04 07954	UNUSED SPACE	0		3,224,413	194.04
194.05 07955	MOB	0		721,082	194.05
194.06 07956	FOUNDATION	0		28,838	194.06
194.07 07957	KNOX COUNTY HEALTH DEPT	0		140,290	194.07
194.08 07958	INDUSTRIAL HEALTH	0		173	194.08

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150042

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

Worksheet B
Part II
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description			MENTAL HEALTH OVERHEAD	PARAMED ED PGRM	PARAMED ED PGRM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			17.01	23.00	23.01	24.00	25.00	
194.09	07959	NRCC	0			985,896		0 194.09
200.00		Cross Foot Adjustments		2,464	135	2,599		0 200.00
201.00		Negative Cost Centers	0	0	0	-11,483		0 201.00
202.00		TOTAL (sum lines 118-201)	154,785	2,464	135	20,794,281		0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/25/2016 9:57 am
Cost Center Description		Total		
		26.00		
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
4.01	00401	COMMUNICATIONS		4.01
4.02	00402	PURCHASING & RECEIVING		4.02
4.03	00403	REGISTRATION		4.03
4.04	00404	PATIENT ACCOUNTS		4.04
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
17.01	01701	MENTAL HEALTH OVERHEAD		17.01
23.00	02300	PARAMED PGRM-(SPECIFY)		23.00
23.01	02302	PARAMED PGRM-(SPECIFY)		23.01
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	2,732,437	30.00
31.00	03100	INTENSIVE CARE UNIT	985,310	31.00
40.00	04000	SUBPROVIDER - IPF	455,027	40.00
41.00	04100	SUBPROVIDER - IRF	792,328	41.00
43.00	04300	NURSERY	14,550	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	676,014	50.00
51.00	05100	RECOVERY ROOM	0	51.00
51.01	05101	ENDOSCOPY	395,933	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,810	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	802,913	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	158,757	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	2,079	54.08
60.00	06000	LABORATORY	334,209	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,307	63.00
65.00	06500	RESPIRATORY THERAPY	199,905	65.00
66.00	06600	PHYSICAL THERAPY	293,954	66.00
69.00	06900	ELECTROCARDIOLOGY	546,971	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
70.01	07001	NEURODIAGNOSTICS	240,461	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	54,268	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,767	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	437,998	73.00
75.00	07500	ASC (NON-DISTINCT PART)	132,240	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	76.00
76.01	03950	INPATIENT DIALYSIS	255,660	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	102,866	90.00
91.00	09100	EMERGENCY	651,338	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	14,136	96.00
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	170,354	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,510,592	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,464,456	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	79,603	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	42,372	194.02
194.03	07953	MH RESIDENTIAL	605,450	194.03
194.04	07954	UNUSED SPACE	3,224,413	194.04
194.05	07955	MOB	721,082	194.05
194.06	07956	FOUNDATION	28,838	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	140,290	194.07
194.08	07958	INDUSTRIAL HEALTH	173	194.08
194.09	07959	NRCC	985,896	194.09
200.00		Cross Foot Adjustments	2,599	200.00
201.00		Negative Cost Centers	-11,483	201.00
202.00		TOTAL (sum lines 118-201)	20,794,281	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150042

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

Worksheet B-1
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	864,933				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		846,308			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,401	4,401	97,157,700		4.00
4.01 00401	COMMUNICATIONS	0	0	249,016	2,272	4.01
4.02 00402	PURCHASING & RECEIVING	15,121	15,121	664,965	24	32,655,530
4.03 00403	REGISTRATION	0	0	806,174	22	20,896
4.04 00404	PATIENT ACCOUNTS	0	0	1,993,539	102	74,179
5.00 00500	ADMINISTRATIVE & GENERAL	46,065	45,660	8,216,822	226	237,324
7.00 00700	OPERATION OF PLANT	140,681	137,503	2,372,517	0	289,981
8.00 00800	LAUNDRY & LINEN SERVICE	5,266	5,266	197,882	0	77,238
9.00 00900	HOUSEKEEPING	7,721	7,616	1,928,989	19	212,494
10.00 01000	DIETARY	0	0	313,190	18	1,186,913
11.00 01100	CAFETERIA	12,512	12,512	1,013,386	1	0
13.00 01300	NURSING ADMINISTRATION	10,429	10,429	1,596,549	37	22,274
14.00 01400	CENTRAL SERVICES & SUPPLY	257	257	356,396	8	94,688
15.00 01500	PHARMACY	6,189	6,051	2,717,907	42	13,978,618
16.00 01600	MEDICAL RECORDS & LIBRARY	4,878	977	2,440,400	81	14,081
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
17.01 01701	MENTAL HEALTH OVERHEAD	3,442	3,442	1,599,246	128	181,190
23.00 02300	PARAMEDICAL PGRM-(SPECIFY)	0	0	190,647	0	236
23.01 02302	PARAMEDICAL PGRM-(SPECIFY)	0	0	12,081	0	1,377
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	75,735	75,613	5,676,255	463	1,540,717
31.00 03100	INTENSIVE CARE UNIT	26,737	26,737	3,466,323	38	286,621
40.00 04000	SUBPROVIDER - I/PF	13,253	13,253	517,403	6	0
41.00 04100	SUBPROVIDER - I/RF	22,179	22,179	2,709,373	76	102,316
43.00 04300	NURSERY	0	0	331,566	0	34,116
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	18,905	18,905	3,637,832	76	1,485,324
51.00 05100	RECOVERY ROOM	0	0	0	0	0
51.01 05101	ENDOSCOPY	12,237	12,237	954,383	23	455,011
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	438,612	0	62,720
54.00 05400	RADIOLOGY-DIAGNOSTIC	23,379	23,379	3,809,996	103	1,048,624
54.01 05401	RADIOLOGY-NON-CAMPUS	4,817	4,817	797,370	0	130,330
54.08 05408	RADIOLOGY-GSH BREAST CENTER	0	0	268,525	0	12,689
60.00 06000	LABORATORY	8,308	8,308	2,438,766	47	2,690,306
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	5,557	5,679	1,913,972	28	257,450
66.00 06600	PHYSICAL THERAPY	8,289	8,289	2,492,400	5	79,340
69.00 06900	ELECTROCARDIOLOGY	16,112	16,112	4,316,569	44	1,084,661
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
70.01 07001	NEURODIAGNOSTICS	7,645	7,645	318,220	23	26,585
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,152,971
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	533,214	0	0
75.00 07500	ASC (NON-DISTINCT PART)	0	0	957,020	64	1,425,568
76.00 03020	MH ANCILLARY OUTPATIENT	0	0	0	0	0
76.01 03950	INPATIENT DIALYSIS	8,582	8,582	0	0	5,888
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	2,668	2,668	1,589,990	0	451,380
91.00 09100	EMERGENCY	16,519	16,519	3,512,751	48	294,123
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	394	394	63,817	0	90,891
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	4,861	4,861	634,217	3	24,077
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	533,139	525,412	68,048,280	1,755	30,133,197
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	136,015	125,117	26,366,442	459	1,677,208
194.00 07950	COMMUNITY HEALTH SERVICES	2,536	2,536	150,830	37	29,886
194.02 07952	MARKETING AND PUBLIC RELATIONS	875	875	169,306	0	655,514
194.03 07953	MH RESIDENTIAL	20,260	20,260	384,948	0	46,750
194.04 07954	UNUSED SPACE	109,530	109,530	0	0	0
194.05 07955	MOB	24,373	24,373	209,629	3	8,603
194.06 07956	FOUNDATION	658	658	117,171	0	104,221

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150042

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

Worksheet B-1

Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
194.07 07957 KNOX COUNTY HEALTH DEPT	4,712	4,712	0	18	0	194.07
194.08 07958 INDUSTRIAL HEALTH	0	0	17,774	0	151	194.08
194.09 07959 NRCC	32,835	32,835	1,693,320	0	0	194.09
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)	20,805,764	-11,483	23,988,825	327,376	998,921	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	24.054770	0.000000	0.246906	144.091549	0.030590	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			105,865	271	364,460	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001090	0.119278	0.011161	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150042

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

Worksheet B-1
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		4.03	4.04	5A	5.00	7.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	PURCHASING & RECEIVING					4.02
4.03	00403	REGISTRATION	482,952,627				4.03
4.04	00404	PATIENT ACCOUNTS	0	482,952,627			4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	-22,092,885	185,708,597	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	10,078,324	658,665
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	536,476	5,266
9.00	00900	HOUSEKEEPING	0	0	0	2,957,505	7,721
10.00	01000	DIETARY	0	0	0	759,503	0
11.00	01100	CAFETERIA	0	0	0	1,676,220	12,512
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,604,731	10,429
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	646,660	257
15.00	01500	PHARMACY	0	0	0	4,334,881	6,189
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	4,153,695	4,878
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	MENTAL HEALTH OVERHEAD	0	0	0	2,247,504	3,442
23.00	02300	PARAMEDICAL PGRM-(SPECIFY)	0	0	0	214,861	0
23.01	02302	PARAMEDICAL PGRM-(SPECIFY)	0	0	0	17,627	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	29,342,072	29,342,072	0	11,278,070	75,735
31.00	03100	INTENSIVE CARE UNIT	15,047,597	15,047,597	0	5,676,100	26,737
40.00	04000	SUBPROVIDER - IPF	5,062,954	5,062,954	0	1,261,668	13,253
41.00	04100	SUBPROVIDER - IRF	7,667,454	7,667,454	0	5,039,490	22,179
43.00	04300	NURSERY	1,114,602	1,114,602	0	479,536	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	27,275,695	27,275,695	0	5,766,944	18,905
51.00	05100	RECOVERY ROOM	0	0	0	0	0
51.01	05101	ENDOSCOPY	12,697,442	12,697,442	0	2,003,203	12,237
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,993,278	3,993,278	0	659,275	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	78,647,688	78,647,688	0	8,459,766	23,379
54.01	05401	RADIOLOGY-NON-CAMPUS	17,672,034	17,672,034	0	1,698,562	4,817
54.08	05408	RADIOLOGY-GSH BREAST CENTER	443,767	443,767	0	270,608	0
60.00	06000	LABORATORY	48,779,038	48,779,038	0	5,679,387	8,308
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,582,356	3,582,356	0	875,530	0
65.00	06500	RESPIRATORY THERAPY	12,668,806	12,668,806	0	2,947,681	5,557
66.00	06600	PHYSICAL THERAPY	29,030,640	29,030,640	0	4,000,355	8,289
69.00	06900	ELECTROCARDIOLOGY	33,053,093	33,053,093	0	4,842,712	16,112
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
70.01	07001	NEURODIAGNOSTICS	5,789,411	5,789,411	0	706,863	7,645
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,084,814	9,084,814	0	8,989,012	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,775,860	11,775,860	0	2,354,889	0
73.00	07300	DRUGS CHARGED TO PATIENTS	59,815,030	59,815,030	0	14,929,092	0
75.00	07500	ASC (NON-DISTINCT PART)	23,152,477	23,152,477	0	2,620,742	0
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	0
76.01	03950	INPATIENT DIALYSIS	1,303,786	1,303,786	0	682,113	8,582
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,230,665	4,230,665	0	1,772,585	2,668
91.00	09100	EMERGENCY	38,066,649	38,066,649	0	5,876,840	16,519
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	632,423	632,423	0	157,256	394
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	3,022,996	3,022,996	0	1,484,853	4,861
118.00		SUBTOTALS (SUM OF LINES 1-117)	482,952,627	482,952,627	-22,092,885	130,741,119	326,871
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	43,791,933	136,015
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	345,105	2,536
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	1,169,947	875
194.03	07953	MH RESIDENTIAL	0	0	0	1,047,567	20,260
194.04	07954	UNUSED SPACE	0	0	0	2,634,719	109,530
194.05	07955	MOB	0	0	0	899,462	24,373
194.06	07956	FOUNDATION	0	0	0	1,256,336	658
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	115,940	4,712
194.08	07958	INDUSTRIAL HEALTH	0	0	0	25,151	0
194.09	07959	NRCC	0	0	0	3,681,318	32,835

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150042

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

Worksheet B-1

Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		4.03	4.04	5A	5.00	7.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,117,260	4,463,133		22,092,885	11,277,292	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.002313	0.009241		0.118965	17.121438	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,115	3,013		1,119,715	3,450,634	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000002	0.000006		0.006029	5.238830	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150042

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

Worksheet B-1

Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		LAUNDRY & LINEN SERVICE (LBS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURSING)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	PURCHASING & RECEIVING					4.02
4.03	00403	REGISTRATION					4.03
4.04	00404	PATIENT ACCOUNTS					4.04
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,164,512				8.00
9.00	00900	HOUSEKEEPING	63,633	66,523			9.00
10.00	01000	DIETARY	17,185	2,034	36,443		10.00
11.00	01100	CAFETERIA	0	431	0	2,477,223	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	39,876	842,361
14.00	01400	CENTRAL SERVICES & SUPPLY	2,786	831	0	25,947	0
15.00	01500	PHARMACY	0	637	0	90,786	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	371	0	124,459	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	MENTAL HEALTH OVERHEAD	19,382	1,846	0	174,261	0
23.00	02300	PARAMED ED PGRM-(SPECIFY)	0	0	0	6,256	0
23.01	02302	PARAMED ED PGRM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	381,441	17,921	16,362	265,587	265,587
31.00	03100	INTENSIVE CARE UNIT	154,036	5,658	6,762	137,319	137,319
40.00	04000	SUBPROVIDER - I/PF	0	0	4,219	61,269	61,269
41.00	04100	SUBPROVIDER - I/RF	79,228	3,387	8,049	128,039	128,039
43.00	04300	NURSERY	10,112	203	1,051	11,813	11,813
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	47,584	4,945	0	58,496	58,496
51.00	05100	RECOVERY ROOM	0	0	0	0	0
51.01	05101	ENDOSCOPY	29,821	1,032	0	33,615	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,991	242	0	15,200	15,200
54.00	05400	RADIOLOGY-DIAGNOSTIC	95,141	3,259	0	137,163	0
54.01	05401	RADIOLOGY-NON-CAMPUS	0	0	0	26,217	0
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0	0	0	0	0
60.00	06000	LABORATORY	0	1,031	0	115,190	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	172	755	0	68,859	0
66.00	06600	PHYSICAL THERAPY	41,437	1,414	0	75,440	0
69.00	06900	ELECTROCARDIOLOGY	19,997	1,976	0	86,122	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
70.01	07001	NEURODIAGNOSTICS	19,266	1,249	0	14,482	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
75.00	07500	ASC (NON-DISTINCT PART)	43,670	3,201	0	0	0
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	0
76.01	03950	INPATIENT DIALYSIS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	28	444	0	31,997	0
91.00	09100	EMERGENCY	98,618	3,122	0	139,810	139,810
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	3,238	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	1,163	0	24,828	24,828
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,133,528	57,152	36,443	1,896,269	842,361
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	30,984	8,565	0	521,695	0
194.00	07950	COMMUNITY HEALTH SERVICES	0	282	0	7,466	0
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	121	0	8,336	0
194.03	07953	MH RESIDENTIAL	0	0	0	30,502	0
194.04	07954	UNUSED SPACE	0	0	0	0	0
194.05	07955	MOB	0	0	0	8,856	0
194.06	07956	FOUNDATION	0	0	0	4,099	0
194.07	07957	KNOX COUNTY HEALTH DEPT	0	403	0	0	0
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150042

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

Worksheet B-1

Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description			LAUNDRY & LINEN SERVICE (LBS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURSING)	
			8.00	9.00	10.00	11.00	13.00	
194.09	07959	NRCC	0	0	0	0	0	194.09
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)	690,459	3,479,269	966,428	2,112,397	3,127,165	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.592917	52.301745	26.518893	0.852728	3.712381	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	158,572	257,149	28,372	379,398	329,307	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.136170	3.865565	0.778531	0.153155	0.390933	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150042

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

Worksheet B-1
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	MENTAL HEALTH OVERHEAD (CHARGES)	
		14.00	15.00	16.00	17.00	17.01	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
4.01	00401						4.01
4.02	00402						4.02
4.03	00403						4.03
4.04	00404						4.04
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400	30,439,543					14.00
15.00	01500	13,978,618	15,580,018				15.00
16.00	01600	14,081	0	1,434			16.00
17.00	01700	0	0	0	0		17.00
17.01	01701	181,190	1,595	0	0	51,680,566	17.01
23.00	02300	236	0	0	0	0	23.00
23.01	02302	1,377	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,540,717	14,884	657	0	18,269,427	30.00
31.00	03100	286,621	10,666	281	0	0	31.00
40.00	04000	0	0	51	0	5,062,954	40.00
41.00	04100	102,316	7,655	60	0	0	41.00
43.00	04300	34,116	420	11	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,485,324	63,219	50	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
51.01	05101	455,011	2,493	42	0	0	51.01
52.00	05200	62,720	707	0	0	0	52.00
54.00	05400	1,048,624	120,243	0	0	0	54.00
54.01	05401	130,330	33,459	0	0	0	54.01
54.08	05408	12,689	0	0	0	0	54.08
60.00	06000	2,690,306	3,281	0	0	0	60.00
63.00	06300	0	0	0	0	0	63.00
65.00	06500	257,450	3,627	4	0	0	65.00
66.00	06600	79,340	18,675	0	0	0	66.00
69.00	06900	1,084,661	1,375	33	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	26,585	26	14	0	0	70.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	2,152,971	0	0	0	0	72.00
73.00	07300	0	13,783,091	0	0	0	73.00
75.00	07500	1,425,568	95,427	62	0	23,152,477	75.00
76.00	03020	0	0	0	0	0	76.00
76.01	03950	5,888	2,759	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	451,380	11,766	0	0	0	90.00
91.00	09100	294,123	11,118	169	0	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	90,891	0	0	0	0	96.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	24,077	22	0	0	0	116.00
118.00		27,917,210	14,186,508	1,434	0	46,484,858	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	1,677,208	1,374,526	0	0	5,195,708	192.00
194.00	07950	29,886	18,984	0	0	0	194.00
194.02	07952	655,514	0	0	0	0	194.02
194.03	07953	46,750	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	8,603	0	0	0	0	194.05
194.06	07956	104,221	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	151	0	0	0	0	194.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150042

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

Worksheet B-1

Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	MENTAL HEALTH OVERHEAD (CHARGES)	
			14.00	15.00	16.00	17.00	17.01	
194.09	07959	NRCC	0	0	0	0	0	194.09
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)	795,231	5,432,465	4,857,259	0	2,835,738	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.026125	0.348682	3,387.209902	0.000000	0.054870	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	20,438	392,163	191,269	0	154,785	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000671	0.025171	133.381450	0.000000	0.002995	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150042

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

Worksheet B-1
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		PARAMED PGRM (ASSIGNED TIME)	PARAMED PGRM (ASSIGNED TIME)	
		23.00	23.01	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
4.01	00401	COMMUNICATIONS		4.01
4.02	00402	PURCHASING & RECEIVING		4.02
4.03	00403	REGISTRATION		4.03
4.04	00404	PATIENT ACCOUNTS		4.04
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
17.01	01701	MENTAL HEALTH OVERHEAD		17.01
23.00	02300	PARAMED PGRM-(SPECIFY)	100	23.00
23.01	02302	PARAMED PGRM-(SPECIFY)		23.01
			100	
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
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
51.01	05101	ENDOSCOPY	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0	54.08
60.00	06000	LABORATORY	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	194.02
194.03	07953	MH RESIDENTIAL	0	194.03
194.04	07954	UNUSED SPACE	0	194.04
194.05	07955	MOB	0	194.05
194.06	07956	FOUNDATION	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	194.08
194.09	07959	NRCC	0	194.09

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150042

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

Worksheet B-1

Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		PARAMED ED PGRM (ASSIGNED TIME)	PARAMED ED PGRM (ASSIGNED TIME)	
		23.00	23.01	
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	245,763	19,760	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2,457.630000	197.600000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	2,464	135	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	24.640000	1.350000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150042

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

Worksheet C
Part I
Date/Time Prepared:
5/25/2016 9:57 am

		Title XVIIII		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	19,999,536		19,999,536	0	19,999,536	30.00
31.00	03100	INTENSIVE CARE UNIT	8,965,597		8,965,597	0	8,965,597	31.00
40.00	04000	SUBPROVIDER - I PF	2,480,807		2,480,807	0	2,480,807	40.00
41.00	04100	SUBPROVIDER - I RF	7,249,409		7,249,409	0	7,249,409	41.00
43.00	04300	NURSERY	673,291		673,291	0	673,291	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,560,781		7,560,781	0	7,560,781	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
51.01	05101	ENDOSCOPY	2,706,368		2,706,368	0	2,706,368	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	827,562		827,562	0	827,562	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,525,374		10,525,374	0	10,525,374	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	2,020,533		2,020,533	0	2,020,533	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	303,133		303,133	600	303,733	54.08
60.00	06000	LABORATORY	6,740,617		6,740,617	0	6,740,617	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	979,687		979,687	0	979,687	63.00
65.00	06500	RESPIRATORY THERAPY	3,513,344	0	3,513,344	0	3,513,344	65.00
66.00	06600	PHYSICAL THERAPY	4,789,616	0	4,789,616	0	4,789,616	66.00
69.00	06900	ELECTROCARDIOLOGY	6,023,924		6,023,924	7,348	6,031,272	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,059,070		1,059,070	13,354	1,072,424	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,058,390		10,058,390	0	10,058,390	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,691,284		2,691,284	0	2,691,284	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,511,039		21,511,039	0	21,511,039	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,676,757		4,676,757	938	4,677,695	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	911,313		911,313	14,186	925,499	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,095,560		2,095,560	16,558	2,112,118	90.00
91.00	09100	EMERGENCY	8,302,812		8,302,812	36,325	8,339,137	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,053,303		2,053,303	0	2,053,303	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	187,846		187,846	0	187,846	96.00
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,919,533		1,919,533		1,919,533	116.00
200.00		Subtotal (see instructions)	140,826,486	0	140,826,486	89,309	140,915,795	200.00
201.00		Less Observation Beds	2,053,303		2,053,303		2,053,303	201.00
202.00		Total (see instructions)	138,773,183	0	138,773,183	89,309	138,862,492	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/25/2016 9:57 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			
9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,269,427		18,269,427	30.00
31.00	03100	INTENSIVE CARE UNIT	15,047,597		15,047,597	31.00
40.00	04000	SUBPROVIDER - IPF	5,062,954		5,062,954	40.00
41.00	04100	SUBPROVIDER - IRF	7,667,454		7,667,454	41.00
43.00	04300	NURSERY	1,114,602		1,114,602	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,054,297	17,221,398	27,275,695	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
51.01	05101	ENDOSCOPY	1,897,380	10,800,062	12,697,442	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,617,140	376,138	3,993,278	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,933,675	66,714,013	78,647,688	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	2,302,043	15,369,991	17,672,034	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	3,271	440,496	443,767	54.08
60.00	06000	LABORATORY	14,226,856	34,552,182	48,779,038	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,907,923	1,674,433	3,582,356	63.00
65.00	06500	RESPIRATORY THERAPY	9,925,571	2,743,235	12,668,806	65.00
66.00	06600	PHYSICAL THERAPY	12,835,842	16,194,798	29,030,640	66.00
69.00	06900	ELECTROCARDIOLOGY	8,454,654	24,598,439	33,053,093	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	212,713	5,576,698	5,789,411	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,820,547	2,264,267	9,084,814	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,949,357	1,826,503	11,775,860	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,591,598	43,223,432	59,815,030	73.00
75.00	07500	ASC (NON-DISTINCT PART)	90,476	23,062,001	23,152,477	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	1,223,245	80,541	1,303,786	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,230,665	4,230,665	90.00
91.00	09100	EMERGENCY	7,362,061	30,704,588	38,066,649	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,354,233	7,718,412	11,072,645	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	80,026	552,397	632,423	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	513,627	2,509,369	3,022,996	116.00
200.00		Subtotal (see instructions)	170,518,569	312,434,058	482,952,627	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	170,518,569	312,434,058	482,952,627	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/25/2016 9:57 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 - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.277198		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
51.01	05101 ENDOSCOPY	0.213143		51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.207239		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133829		54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0.114335		54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	0.684443		54.08
60.00	06000 LABORATORY	0.138187		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.273476		63.00
65.00	06500 RESPIRATORY THERAPY	0.277322		65.00
66.00	06600 PHYSICAL THERAPY	0.164985		66.00
69.00	06900 ELECTROCARDIOLOGY	0.182472		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001 NEURODIAGNOSTICS	0.185239		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.107165		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.228542		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.359626		73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.202039		75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0.000000		76.00
76.01	03950 INPATIENT DIALYSIS	0.709855		76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.499240		90.00
91.00	09100 EMERGENCY	0.219067		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.185439		92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.297026		96.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150042

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

Worksheet C
Part I
Date/Time Prepared:
5/25/2016 9:57 am

		Title XIX		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,999,536		19,999,536	0	19,999,536	30.00
31.00	03100	INTENSIVE CARE UNIT	8,965,597		8,965,597	0	8,965,597	31.00
40.00	04000	SUBPROVIDER - I PF	2,480,807		2,480,807	0	2,480,807	40.00
41.00	04100	SUBPROVIDER - I RF	7,249,409		7,249,409	0	7,249,409	41.00
43.00	04300	NURSERY	673,291		673,291	0	673,291	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,560,781		7,560,781	0	7,560,781	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
51.01	05101	ENDOSCOPY	2,706,368		2,706,368	0	2,706,368	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	827,562		827,562	0	827,562	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,525,374		10,525,374	0	10,525,374	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	2,020,533		2,020,533	0	2,020,533	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	303,133		303,133	600	303,733	54.08
60.00	06000	LABORATORY	6,740,617		6,740,617	0	6,740,617	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	979,687		979,687	0	979,687	63.00
65.00	06500	RESPIRATORY THERAPY	3,513,344	0	3,513,344	0	3,513,344	65.00
66.00	06600	PHYSICAL THERAPY	4,789,616	0	4,789,616	0	4,789,616	66.00
69.00	06900	ELECTROCARDIOLOGY	6,023,924		6,023,924	7,348	6,031,272	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,059,070		1,059,070	13,354	1,072,424	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,058,390		10,058,390	0	10,058,390	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,691,284		2,691,284	0	2,691,284	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,511,039		21,511,039	0	21,511,039	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,676,757		4,676,757	938	4,677,695	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	911,313		911,313	14,186	925,499	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,095,560		2,095,560	16,558	2,112,118	90.00
91.00	09100	EMERGENCY	8,302,812		8,302,812	36,325	8,339,137	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,053,303		2,053,303	0	2,053,303	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	187,846		187,846	0	187,846	96.00
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,919,533		1,919,533		1,919,533	116.00
200.00		Subtotal (see instructions)	140,826,486	0	140,826,486	89,309	140,915,795	200.00
201.00		Less Observation Beds	2,053,303		2,053,303		2,053,303	201.00
202.00		Total (see instructions)	138,773,183	0	138,773,183	89,309	138,862,492	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/25/2016 9:57 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	18,269,427		18,269,427	30.00
31.00	03100	INTENSIVE CARE UNIT	15,047,597		15,047,597	31.00
40.00	04000	SUBPROVIDER - I/PF	5,062,954		5,062,954	40.00
41.00	04100	SUBPROVIDER - I/PF	7,667,454		7,667,454	41.00
43.00	04300	NURSERY	1,114,602		1,114,602	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,054,297	17,221,398	27,275,695	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
51.01	05101	ENDOSCOPY	1,897,380	10,800,062	12,697,442	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,617,140	376,138	3,993,278	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,933,675	66,714,013	78,647,688	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	2,302,043	15,369,991	17,672,034	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	3,271	440,496	443,767	54.08
60.00	06000	LABORATORY	14,226,856	34,552,182	48,779,038	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,907,923	1,674,433	3,582,356	63.00
65.00	06500	RESPIRATORY THERAPY	9,925,571	2,743,235	12,668,806	65.00
66.00	06600	PHYSICAL THERAPY	12,835,842	16,194,798	29,030,640	66.00
69.00	06900	ELECTROCARDIOLOGY	8,454,654	24,598,439	33,053,093	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	212,713	5,576,698	5,789,411	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,820,547	2,264,267	9,084,814	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,949,357	1,826,503	11,775,860	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,591,598	43,223,432	59,815,030	73.00
75.00	07500	ASC (NON-DISTINCT PART)	90,476	23,062,001	23,152,477	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	1,223,245	80,541	1,303,786	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,230,665	4,230,665	90.00
91.00	09100	EMERGENCY	7,362,061	30,704,588	38,066,649	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,354,233	7,718,412	11,072,645	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	80,026	552,397	632,423	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	513,627	2,509,369	3,022,996	116.00
200.00		Subtotal (see instructions)	170,518,569	312,434,058	482,952,627	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	170,518,569	312,434,058	482,952,627	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/25/2016 9:57 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
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
51.01	05101 ENDOSCOPY	0.000000		51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0.000000		54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	0.000000		54.08
60.00	06000 LABORATORY	0.000000		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001 NEURODIAGNOSTICS	0.000000		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0.000000		76.00
76.01	03950 INPATIENT DIALYSIS	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part I Date/Time Prepared: 5/25/2016 9:57 am
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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	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,732,437	0	2,732,437	18,107	150.91	30.00
31.00	INTENSIVE CARE UNIT	985,310	0	985,310	6,762	145.71	31.00
40.00	SUBPROVIDER - IPF	455,027	0	455,027	4,219	107.85	40.00
41.00	SUBPROVIDER - IRF	792,328	0	792,328	8,049	98.44	41.00
43.00	NURSERY	14,550	0	14,550	1,051	13.84	43.00
200.00	Total (lines 30-199)	4,979,652		4,979,652	38,188		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	10,646	1,606,588				
31.00	INTENSIVE CARE UNIT	3,158	460,152				
40.00	SUBPROVIDER - IPF	1,868	201,464				
41.00	SUBPROVIDER - IRF	6,500	639,860				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	22,172	2,908,064				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150042

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

Worksheet D
Part II
Date/Time Prepared:
5/25/2016 9:57 am

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	676,014	27,275,695	0.024784	8,611,269	213,422	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	395,933	12,697,442	0.031182	1,058,326	33,001	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,810	3,993,278	0.003959	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	802,913	78,647,688	0.010209	7,176,027	73,260	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	158,757	17,672,034	0.008984	1,172,774	10,536	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	2,079	443,767	0.004685	0	0	54.08
60.00	06000	LABORATORY	334,209	48,779,038	0.006851	9,171,017	62,831	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,307	3,582,356	0.001481	1,223,641	1,812	63.00
65.00	06500	RESPIRATORY THERAPY	199,905	12,668,806	0.015779	5,497,527	86,745	65.00
66.00	06600	PHYSICAL THERAPY	293,954	29,030,640	0.010126	3,807,636	38,556	66.00
69.00	06900	ELECTROCARDIOLOGY	546,971	33,053,093	0.016548	6,163,907	102,000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	240,461	5,789,411	0.041535	121,017	5,026	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	54,268	9,084,814	0.005973	2,657,565	15,874	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,767	11,775,860	0.003377	3,998,701	13,504	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	437,998	59,815,030	0.007323	9,476,840	69,399	73.00
75.00	07500	ASC (NON-DISTINCT PART)	132,240	23,152,477	0.005712	0	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	255,660	1,303,786	0.196090	961,918	188,623	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	102,866	4,230,665	0.024314	0	0	90.00
91.00	09100	EMERGENCY	651,338	38,066,649	0.017110	3,198,012	54,718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	280,533	11,072,645	0.025336	1,100,496	27,882	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	14,136	632,423	0.022352	0	0	96.00
200.00		Total (lines 50-199)	5,641,119	432,767,597		65,396,673	997,189	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150042		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part III Date/Time Prepared: 5/25/2016 9:57 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	18,107	0.00	10,646	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,762	0.00	3,158	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	4,219	0.00	1,868	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	8,049	0.00	6,500	0	0	41.00
43.00	04300	NURSERY	1,051	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	38,188		22,172	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 9:57 am
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Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	245,763	0	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0	0	0	0	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0	0	0	0	54.08
60.00	06000	LABORATORY	0	0	19,760	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	265,523	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 9:57 am
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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	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	27,275,695	0.000000	0.000000	8,611,269	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
51.01	05101 ENDOSCOPY	0	12,697,442	0.000000	0.000000	1,058,326	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3,993,278	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	245,763	78,647,688	0.003125	0.003125	7,176,027	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0	17,672,034	0.000000	0.000000	1,172,774	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	0	443,767	0.000000	0.000000	0	54.08
60.00	06000 LABORATORY	19,760	48,779,038	0.000405	0.000405	9,171,017	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	3,582,356	0.000000	0.000000	1,223,641	63.00
65.00	06500 RESPIRATORY THERAPY	0	12,668,806	0.000000	0.000000	5,497,527	65.00
66.00	06600 PHYSICAL THERAPY	0	29,030,640	0.000000	0.000000	3,807,636	66.00
69.00	06900 ELECTROCARDIOLOGY	0	33,053,093	0.000000	0.000000	6,163,907	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
70.01	07001 NEURODIAGNOSTICS	0	5,789,411	0.000000	0.000000	121,017	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,084,814	0.000000	0.000000	2,657,565	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	11,775,860	0.000000	0.000000	3,998,701	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	59,815,030	0.000000	0.000000	9,476,840	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	23,152,477	0.000000	0.000000	0	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0	0	0.000000	0.000000	0	76.00
76.01	03950 INPATIENT DIALYSIS	0	1,303,786	0.000000	0.000000	961,918	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	4,230,665	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	38,066,649	0.000000	0.000000	3,198,012	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	11,072,645	0.000000	0.000000	1,100,496	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	632,423	0.000000	0.000000	0	96.00
200.00	Total (Lines 50-199)	265,523	432,767,597			65,396,673	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 9:57 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	15,410,940	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
51.01	05101 ENDOSCOPY	0	4,773,451	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	22,425	25,357,151	79,241	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0	4,378,942	0	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	0	0	0	54.08
60.00	06000 LABORATORY	3,714	5,751,152	2,329	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	776,376	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	2,313,822	0	65.00
66.00	06600 PHYSICAL THERAPY	0	7,179	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	7,530,545	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0	1,976,175	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,877,877	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,502,465	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	23,579,043	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0	0	0	76.00
76.01	03950 INPATIENT DIALYSIS	0	59,109	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	7,535,001	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,063,246	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00	Total (Lines 50-199)	26,139	104,892,474	81,570	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/25/2016 9:57 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	0.277198	15,410,940	62	0	4,271,882	50.00
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01 05101 ENDOSCOPY	0.213143	4,773,451	0	0	1,017,428	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.207239	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.133829	25,357,151	48	0	3,393,522	54.00
54.01 05401 RADIOLOGY-NON-CAMPUS	0.114335	4,378,942	143	0	500,666	54.01
54.08 05408 RADIOLOGY-GSH BREAST CENTER	0.683090	0	0	0	0	54.08
60.00 06000 LABORATORY	0.138187	5,751,152	19,916	0	794,734	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.273476	776,376	0	0	212,320	63.00
65.00 06500 RESPIRATORY THERAPY	0.277322	2,313,822	0	0	641,674	65.00
66.00 06600 PHYSICAL THERAPY	0.164985	7,179	0	0	1,184	66.00
69.00 06900 ELECTROCARDIOLOGY	0.182250	7,530,545	0	0	1,372,442	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01 07001 NEURODIAGNOSTICS	0.182932	1,976,175	0	0	361,506	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.107165	1,877,877	307	0	2,079,120	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.228542	1,502,465	0	0	343,376	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.359626	23,579,043	486	157,156	8,479,637	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0.201998	0	0	0	0	75.00
76.00 03020 MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01 03950 INPATIENT DIALYSIS	0.698974	59,109	0	0	41,316	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.495326	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.218113	7,535,001	0	0	1,643,482	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.185439	2,063,246	0	0	382,606	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.297026	0	0	0	0	96.00
200.00	Subtotal (see instructions)	104,892,474	20,962	157,156	25,536,895	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0		201.00
202.00	Net Charges (line 200 +/- line 201)	104,892,474	20,962	157,156	25,536,895	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/25/2016 9:57 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	17	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
51.01 05101 ENDOSCOPY	0	0		51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	6	0		54.00
54.01 05401 RADIOLOGY-NON-CAMPUS	16	0		54.01
54.08 05408 RADIOLOGY-GSH BREAST CENTER	0	0		54.08
60.00 06000 LABORATORY	2,752	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01 07001 NEURODIAGNOSTICS	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	340	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	175	56,517		73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.00 03020 MH ANCILLARY OUTPATIENT	0	0		76.00
76.01 03950 INPATIENT DIALYSIS	0	0		76.01
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
OTHER REIMBURSABLE COST CENTERS				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	3,306	56,517		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	3,306	56,517		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150042 Component CCN: 15S042		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part II Date/Time Prepared: 5/25/2016 9:57 am		
		Title XVIII		Subprovider - IPF		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	676,014	27,275,695	0.024784	7,848	195	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	395,933	12,697,442	0.031182	112	3	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,810	3,993,278	0.003959	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	802,913	78,647,688	0.010209	61,869	632	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	158,757	17,672,034	0.008984	8,182	74	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	2,079	443,767	0.004685	0	0	54.08
60.00	06000	LABORATORY	334,209	48,779,038	0.006851	151,947	1,041	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,307	3,582,356	0.001481	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	199,905	12,668,806	0.015779	128,788	2,032	65.00
66.00	06600	PHYSICAL THERAPY	293,954	29,030,640	0.010126	67,932	688	66.00
69.00	06900	ELECTROCARDIOLOGY	546,971	33,053,093	0.016548	16,423	272	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	240,461	5,789,411	0.041535	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	54,268	9,084,814	0.005973	4,041	24	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,767	11,775,860	0.003377	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	437,998	59,815,030	0.007323	167,858	1,229	73.00
75.00	07500	ASC (NON-DISTINCT PART)	132,240	23,152,477	0.005712	0	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	255,660	1,303,786	0.196090	7,831	1,536	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	102,866	4,230,665	0.024314	0	0	90.00
91.00	09100	EMERGENCY	651,338	38,066,649	0.017110	152,363	2,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	11,072,645	0.000000	10,210	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	14,136	632,423	0.022352	0	0	96.00
200.00		Total (lines 50-199)	5,360,586	432,767,597		785,404	10,333	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150042 Component CCN: 15S042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 9:57 am
	Title XVIII	Subprovider - IPF	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
51.01	05101 ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	245,763	0	245,763	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0	0	0	0	0	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	0	0	0	0	0	54.08
60.00	06000 LABORATORY	0	0	19,760	0	19,760	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950 INPATIENT DIALYSIS	0	0	0	0	0	76.01
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
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50-199)	0	0	265,523	0	265,523	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150042 Component CCN: 15S042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 9:57 am
Title XVIII		Subprovider - IPF	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	27,275,695	0.000000	0.000000	7,848	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
51.01	05101 ENDOSCOPY	0	12,697,442	0.000000	0.000000	112	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3,993,278	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	245,763	78,647,688	0.003125	0.003125	61,869	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0	17,672,034	0.000000	0.000000	8,182	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	0	443,767	0.000000	0.000000	0	54.08
60.00	06000 LABORATORY	19,760	48,779,038	0.000405	0.000405	151,947	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	3,582,356	0.000000	0.000000	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	12,668,806	0.000000	0.000000	128,788	65.00
66.00	06600 PHYSICAL THERAPY	0	29,030,640	0.000000	0.000000	67,932	66.00
69.00	06900 ELECTROCARDIOLOGY	0	33,053,093	0.000000	0.000000	16,423	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
70.01	07001 NEURODIAGNOSTICS	0	5,789,411	0.000000	0.000000	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,084,814	0.000000	0.000000	4,041	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	11,775,860	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	59,815,030	0.000000	0.000000	167,858	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	23,152,477	0.000000	0.000000	0	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0	0	0.000000	0.000000	0	76.00
76.01	03950 INPATIENT DIALYSIS	0	1,303,786	0.000000	0.000000	7,831	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	4,230,665	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	38,066,649	0.000000	0.000000	152,363	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	11,072,645	0.000000	0.000000	10,210	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	632,423	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	265,523	432,767,597			785,404	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 9:57 am
	Component CCN: 15S042	Title XVIII	Subprovider - IPF 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	1,796	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
51.01	05101 ENDOSCOPY	0	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	193	0	0	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0	0	0	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	0	0	0	54.08
60.00	06000 LABORATORY	62	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0	0	0	76.00
76.01	03950 INPATIENT DIALYSIS	0	0	0	76.01
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
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00	Total (lines 50-199)	255	1,796	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/25/2016 9:57 am
		Component CCN: 15S042	Title XVIII	Subprovider - IPF
				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	0.277198	1,796	0	0	498	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.213143	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.207239	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133829	0	0	0	0	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0.114335	0	0	0	0	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0.683090	0	0	0	0	54.08
60.00	06000	LABORATORY	0.138187	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.273476	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.277322	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.164985	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.182250	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.182932	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.107165	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.228542	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.359626	0	0	2,672	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.201998	0	0	0	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.698974	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.495326	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.218113	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.185439	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.297026	0	0	0	0	96.00
200.00		Subtotal (see instructions)		1,796	0	2,672	498	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		1,796	0	2,672	498	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150042 Component CCN: 15S042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/25/2016 9:57 am
	Title XVII I	Subprovider - IPF	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
51.01 05101 ENDOSCOPY	0	0	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401 RADIOLOGY-NON-CAMPUS	0	0	54.01
54.08 05408 RADIOLOGY-GSH BREAST CENTER	0	0	54.08
60.00 06000 LABORATORY	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01 07001 NEURODIAGNOSTICS	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	961	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	75.00
76.00 03020 MH ANCILLARY OUTPATIENT	0	0	76.00
76.01 03950 INPATIENT DIALYSIS	0	0	76.01
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
OTHER REIMBURSABLE COST CENTERS			
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00 Subtotal (see instructions)	0	961	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	961	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150042		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part II Date/Time Prepared: 5/25/2016 9:57 am	
		Component CCN: 15T042		Title XVIII		Subprovider - IRF	
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	676,014	27,275,695	0.024784	83,661	2,073
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0
51.01	05101	ENDOSCOPY	395,933	12,697,442	0.031182	58,637	1,828
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,810	3,993,278	0.003959	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	802,913	78,647,688	0.010209	381,565	3,895
54.01	05401	RADIOLOGY-NON-CAMPUS	158,757	17,672,034	0.008984	71,106	639
54.08	05408	RADIOLOGY-GSH BREAST CENTER	2,079	443,767	0.004685	0	0
60.00	06000	LABORATORY	334,209	48,779,038	0.006851	787,117	5,393
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,307	3,582,356	0.001481	17,445	26
65.00	06500	RESPIRATORY THERAPY	199,905	12,668,806	0.015779	803,449	12,678
66.00	06600	PHYSICAL THERAPY	293,954	29,030,640	0.010126	5,913,748	59,883
69.00	06900	ELECTROCARDIOLOGY	546,971	33,053,093	0.016548	105,894	1,752
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0
70.01	07001	NEURODIAGNOSTICS	240,461	5,789,411	0.041535	22,440	932
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	54,268	9,084,814	0.005973	223,766	1,337
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,767	11,775,860	0.003377	7,968	27
73.00	07300	DRUGS CHARGED TO PATIENTS	437,998	59,815,030	0.007323	907,917	6,649
75.00	07500	ASC (NON-DISTINCT PART)	132,240	23,152,477	0.005712	0	0
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0
76.01	03950	INPATIENT DIALYSIS	255,660	1,303,786	0.196090	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	102,866	4,230,665	0.024314	0	0
91.00	09100	EMERGENCY	651,338	38,066,649	0.017110	90,291	1,545
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	11,072,645	0.000000	202,628	0
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	14,136	632,423	0.022352	0	0
200.00		Total (lines 50-199)	5,360,586	432,767,597		9,677,632	98,657

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150042 Component CCN: 15T042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 9:57 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
51.01	05101 ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	245,763	0	245,763	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0	0	0	0	0	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	0	0	0	0	0	54.08
60.00	06000 LABORATORY	0	0	19,760	0	19,760	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950 INPATIENT DIALYSIS	0	0	0	0	0	76.01
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
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50-199)	0	0	265,523	0	265,523	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150042 Component CCN: 15T042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 9:57 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges	
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	27,275,695	0.000000	0.000000	83,661	50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
51.01 05101 ENDOSCOPY	0	12,697,442	0.000000	0.000000	58,637	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	3,993,278	0.000000	0.000000	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	245,763	78,647,688	0.003125	0.003125	381,565	54.00
54.01 05401 RADIOLOGY-NON-CAMPUS	0	17,672,034	0.000000	0.000000	71,106	54.01
54.08 05408 RADIOLOGY-GSH BREAST CENTER	0	443,767	0.000000	0.000000	0	54.08
60.00 06000 LABORATORY	19,760	48,779,038	0.000405	0.000405	787,117	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	3,582,356	0.000000	0.000000	17,445	63.00
65.00 06500 RESPIRATORY THERAPY	0	12,668,806	0.000000	0.000000	803,449	65.00
66.00 06600 PHYSICAL THERAPY	0	29,030,640	0.000000	0.000000	5,913,748	66.00
69.00 06900 ELECTROCARDIOLOGY	0	33,053,093	0.000000	0.000000	105,894	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
70.01 07001 NEURODIAGNOSTICS	0	5,789,411	0.000000	0.000000	22,440	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,084,814	0.000000	0.000000	223,766	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	11,775,860	0.000000	0.000000	7,968	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	59,815,030	0.000000	0.000000	907,917	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	23,152,477	0.000000	0.000000	0	75.00
76.00 03020 MH ANCILLARY OUTPATIENT	0	0	0.000000	0.000000	0	76.00
76.01 03950 INPATIENT DIALYSIS	0	1,303,786	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	4,230,665	0.000000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	38,066,649	0.000000	0.000000	90,291	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	11,072,645	0.000000	0.000000	202,628	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	632,423	0.000000	0.000000	0	96.00
200.00 Total (lines 50-199)	265,523	432,767,597			9,677,632	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150042 Component CCN: 15T042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 9:57 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	1,197	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
51.01	05101 ENDOSCOPY	0	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,192	0	0	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0	0	0	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	0	0	0	54.08
60.00	06000 LABORATORY	319	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0	0	0	76.00
76.01	03950 INPATIENT DIALYSIS	0	0	0	76.01
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
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00	Total (lines 50-199)	1,511	1,197	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/25/2016 9:57 am
		Component CCN: 15T042	Title XVIII	Subprovider - IRF
				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	0.277198	1,197	0	0	332 50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0 51.00
51.01	05101 ENDOSCOPY	0.213143	0	0	0	0 51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.207239	0	0	0	0 52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133829	0	0	0	0 54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0.114335	0	0	0	0 54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	0.683090	0	0	0	0 54.08
60.00	06000 LABORATORY	0.138187	0	0	0	0 60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.273476	0	0	0	0 63.00
65.00	06500 RESPIRATORY THERAPY	0.277322	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.164985	0	0	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	0.182250	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0 70.00
70.01	07001 NEURODIAGNOSTICS	0.182932	0	0	0	0 70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.107165	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.228542	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.359626	0	0	4,042	0 73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.201998	0	0	0	0 75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0 76.00
76.01	03950 INPATIENT DIALYSIS	0.698974	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.495326	0	0	0	0 90.00
91.00	09100 EMERGENCY	0.218113	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.185439	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.297026	0	0	0	0 96.00
200.00	Subtotal (see instructions)		1,197	0	4,042	332 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		1,197	0	4,042	332 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150042 Component CCN: 15T042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/25/2016 9:57 am
	Title XVII I	Subprovider - IRF	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
51.01 05101 ENDOSCOPY	0	0		51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 RADIOLOGY-NON-CAMPUS	0	0		54.01
54.08 05408 RADIOLOGY-GSH BREAST CENTER	0	0		54.08
60.00 06000 LABORATORY	0	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01 07001 NEURODIAGNOSTICS	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1,454		73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.00 03020 MH ANCILLARY OUTPATIENT	0	0		76.00
76.01 03950 INPATIENT DIALYSIS	0	0		76.01
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
OTHER REIMBURSABLE COST CENTERS				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	0	1,454		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	1,454		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/25/2016 9:57 am
		Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.277198	0	1,807,403	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101 ENDOSCOPY	0.213143	0	1,275,669	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.207239	0	44,428	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133829	0	7,880,049	0	0	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0.114335	0	1,815,455	0	0	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	0.683090	0	52,030	0	0	54.08
60.00	06000 LABORATORY	0.138187	0	4,081,195	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.273476	0	197,779	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.277322	0	324,022	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.164985	0	1,912,878	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.182250	0	2,905,490	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0.182932	0	658,702	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.107165	0	267,448	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.228542	0	215,741	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.359626	0	5,105,415	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.201998	0	2,724,011	0	0	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03950 INPATIENT DIALYSIS	0.698974	0	9,513	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.495326	0	499,713	0	0	90.00
91.00	09100 EMERGENCY	0.218113	0	3,626,729	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.185439	0	911,674	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.297026	0	65,247	0	0	96.00
200.00	Subtotal (see instructions)		0	36,380,591	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	36,380,591	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/25/2016 9:57 am
	Title XIX	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	501,008	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
51.01 05101 ENDOSCOPY	271,900	0		51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	9,207	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,054,579	0		54.00
54.01 05401 RADIOLOGY-NON-CAMPUS	207,570	0		54.01
54.08 05408 RADIOLOGY-GSH BREAST CENTER	35,541	0		54.08
60.00 06000 LABORATORY	563,968	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	54,088	0		63.00
65.00 06500 RESPIRATORY THERAPY	89,858	0		65.00
66.00 06600 PHYSICAL THERAPY	315,596	0		66.00
69.00 06900 ELECTROCARDIOLOGY	529,526	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01 07001 NEURODIAGNOSTICS	120,498	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	296,109	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	49,306	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,836,040	0		73.00
75.00 07500 ASC (NON-DISTINCT PART)	550,245	0		75.00
76.00 03020 MH ANCILLARY OUTPATIENT	0	0		76.00
76.01 03950 INPATIENT DIALYSIS	6,649	0		76.01
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	247,521	0		90.00
91.00 09100 EMERGENCY	791,037	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	169,060	0		92.00
OTHER REIMBURSABLE COST CENTERS				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	19,380	0		96.00
200.00	Subtotal (see instructions)	7,718,686	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	7,718,686	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/25/2016 9:57 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)		18,107	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		18,107	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)		16,248	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)		10,646	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)		19,999,536	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)		19,999,536	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)		19,999,536	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)		1,104.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		11,758,720	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)		11,758,720	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150042		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/25/2016 9:57 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	8,965,597	6,762	1,325.88	3,158	4,187,129		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)					17,460,776		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					33,406,625		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)					2,066,740		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,023,328		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					3,090,068		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					30,316,557		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					1,859		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,104.52		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,053,303		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150042		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/25/2016 9:57 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	2,732,437	19,999,536	0.136625	2,053,303	280,533	90.00
91.00	Nursing School cost	0	19,999,536	0.000000	2,053,303	0	91.00
92.00	Allied health cost	0	19,999,536	0.000000	2,053,303	0	92.00
93.00	All other Medical Education	0	19,999,536	0.000000	2,053,303	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Component CCN: 15S042		Date/Time Prepared: 5/25/2016 9:57 am
		Title XVIII	Subprovider - IPF	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)		4,219	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,219	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)		4,219	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)		1,868	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)		2,480,807	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)		2,480,807	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)		2,480,807	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)		588.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,098,403	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)		1,098,403	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150042		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
		Component CCN: 15S042				Date/Time Prepared: 5/25/2016 9:57 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							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)					188,002		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,286,405		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)					201,464		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					10,588		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					212,052		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,074,353		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: 150042 Component CCN: 15S042		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/25/2016 9:57 am	
		Title XVIII		Subprovider - IPF		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	455,027	2,480,807	0.183419	0	0	90.00
91.00	Nursing School cost	0	2,480,807	0.000000	0	0	91.00
92.00	Allied health cost	0	2,480,807	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,480,807	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Component CCN: 15T042		Date/Time Prepared: 5/25/2016 9:57 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)		8,049	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,049	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)		8,049	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)		6,500	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)		7,249,409	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)		7,249,409	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)		7,249,409	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)		900.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,854,290	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		5,854,290	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150042		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
		Component CCN: 15T042				Date/Time Prepared: 5/25/2016 9:57 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		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)					2,063,830		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,918,120		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)					639,860		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					100,168		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					740,028		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					7,178,092		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: 150042 Component CCN: 15T042		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/25/2016 9:57 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	792,328	7,249,409	0.109296	0	0	90.00
91.00	Nursing School cost	0	7,249,409	0.000000	0	0	91.00
92.00	Allied health cost	0	7,249,409	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,249,409	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/25/2016 9:57 am
		Title XVIII	Hospital	PPS

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT		13,292,698	31.00
40.00	04000	SUBPROVIDER - IPF		6,160,875	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.277198	8,611,269	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
51.01	05101	ENDOSCOPY	0.213143	1,058,326	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.207239	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133829	7,176,027	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0.114335	1,172,774	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0.684443	0	54.08
60.00	06000	LABORATORY	0.138187	9,171,017	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.273476	1,223,641	63.00
65.00	06500	RESPIRATORY THERAPY	0.277322	5,497,527	65.00
66.00	06600	PHYSICAL THERAPY	0.164985	3,807,636	66.00
69.00	06900	ELECTROCARDIOLOGY	0.182472	6,163,907	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.185239	121,017	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.107165	2,657,565	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.228542	3,998,701	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.359626	9,476,840	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.202039	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.709855	961,918	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.499240	0	90.00
91.00	09100	EMERGENCY	0.219067	3,198,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.185439	1,100,496	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.297026	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		65,396,673	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)		65,396,673	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3	
		Component CCN: 15S042		Date/Time Prepared: 5/25/2016 9:57 am	
		Title XVIII	Subprovider - IPF	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		2,248,108	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.277198	7,848	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
51.01	05101	ENDOSCOPY	0.213143	112	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.207239	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133829	61,869	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0.114335	8,182	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0.684443	0	54.08
60.00	06000	LABORATORY	0.138187	151,947	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.273476	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.277322	128,788	65.00
66.00	06600	PHYSICAL THERAPY	0.164985	67,932	66.00
69.00	06900	ELECTROCARDIOLOGY	0.182472	16,423	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.185239	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.107165	4,041	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.228542	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.359626	167,858	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.202039	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.709855	7,831	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.499240	0	90.00
91.00	09100	EMERGENCY	0.219067	152,363	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.185439	10,210	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.297026	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		785,404	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)		785,404	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3	
		Component CCN: 15T042		Date/Time Prepared: 5/25/2016 9:57 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		6,187,740	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.277198	83,661	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
51.01	05101	ENDOSCOPY	0.213143	58,637	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.207239	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133829	381,565	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0.114335	71,106	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0.684443	0	54.08
60.00	06000	LABORATORY	0.138187	787,117	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.273476	17,445	63.00
65.00	06500	RESPIRATORY THERAPY	0.277322	803,449	65.00
66.00	06600	PHYSICAL THERAPY	0.164985	5,913,748	66.00
69.00	06900	ELECTROCARDIOLOGY	0.182472	105,894	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.185239	22,440	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.107165	223,766	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.228542	7,968	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.359626	907,917	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.202039	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.709855	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.499240	0	90.00
91.00	09100	EMERGENCY	0.219067	90,291	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.185439	202,628	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.297026	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		9,677,632	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)		9,677,632	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/25/2016 9:57 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		1,280,009	30.00
31.00	03100	INTENSIVE CARE UNIT		1,054,279	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		78,092	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.277198	838,924	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
51.01	05101	ENDOSCOPY	0.213143	132,936	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.207239	253,427	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133829	836,108	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0.114335	161,288	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0.683090	229	54.08
60.00	06000	LABORATORY	0.138187	996,775	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.273476	133,675	63.00
65.00	06500	RESPIRATORY THERAPY	0.277322	695,415	65.00
66.00	06600	PHYSICAL THERAPY	0.164985	899,317	66.00
69.00	06900	ELECTROCARDIOLOGY	0.182250	592,358	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.182932	14,903	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.107165	477,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.228542	697,081	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.359626	1,162,456	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.201998	6,339	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.698974	85,704	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.495326	0	90.00
91.00	09100	EMERGENCY	0.218113	515,808	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.185439	235,007	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.297026	5,607	96.00
200.00		Total (sum of lines 50-94 and 96-98)		8,741,224	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)		8,741,224	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3	
		Component CCN: 15S042		Date/Time Prepared: 5/25/2016 9:57 am	
		Title XIX	Subprovider - IPF	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		291,712	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.277198	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
51.01	05101	ENDOSCOPY	0.213143	106	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.207239	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133829	8,087	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0.114335	474	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0.683090	0	54.08
60.00	06000	LABORATORY	0.138187	19,277	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.273476	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.277322	5,393	65.00
66.00	06600	PHYSICAL THERAPY	0.164985	4,722	66.00
69.00	06900	ELECTROCARDIOLOGY	0.182250	1,423	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.182932	416	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.107165	988	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.228542	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.359626	21,744	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.201998	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.698974	383	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.495326	0	90.00
91.00	09100	EMERGENCY	0.218113	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.185439	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.297026	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		63,013	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)		63,013	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3	
		Component CCN: 15T042		Date/Time Prepared: 5/25/2016 9:57 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		239,797	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.277198	743	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
51.01	05101	ENDOSCOPY	0.213143	1,925	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.207239	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133829	15,205	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0.114335	3,538	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0.683090	0	54.08
60.00	06000	LABORATORY	0.138187	27,041	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.273476	625	63.00
65.00	06500	RESPIRATORY THERAPY	0.277322	8,504	65.00
66.00	06600	PHYSICAL THERAPY	0.164985	196,863	66.00
69.00	06900	ELECTROCARDIOLOGY	0.182250	3,573	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.182932	451	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.107165	7,128	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.228542	275	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.359626	28,473	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.201998	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.698974	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.495326	0	90.00
91.00	09100	EMERGENCY	0.218113	3,065	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.185439	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.297026	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		297,409	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)		297,409	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/25/2016 9:57 am
		Title XVIII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		21,575,303	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)		733,734	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)		186.91	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.43	30.00
31.00	Percentage of Medicaid patient days (see instructions)		14.39	31.00
32.00	Sum of lines 30 and 31		19.82	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.63	33.00
34.00	Disproportionate share adjustment (see instructions)		303,673	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/25/2016 9:57 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)		0.000099357	0.000104473	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		759,847	669,269	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		568,324	168,231	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		736,555		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		23,349,265		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		23,349,265		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,779,598		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		56,514		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		26,139		58.00
59.00	Total (sum of amounts on lines 49 through 58)		25,211,516		59.00
60.00	Primary payer payments		10,564		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		25,200,952		61.00
62.00	Deductibles billed to program beneficiaries		2,604,426		62.00
63.00	Coinurance billed to program beneficiaries		63,945		63.00
64.00	Allowable bad debts (see instructions)		249,711		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		162,312		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		145,319		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		22,694,893		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)		128,945		70.93
70.94	HRR adjustment amount (see instructions)		-49,620		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/25/2016 9:57 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	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)		22,774,218		71.00
71.01	Sequestration adjustment (see instructions)		455,484		71.01
72.00	Interim payments		22,145,937		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)		172,797		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		162,808		75.00
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1 1.00	On/After 10/1 2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150042

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/25/2016 9:57 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	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	21,575,303	0	0	21,575,303	21,575,303	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	733,734	0	0	733,734	733,734	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	0.0563	0.0563	0.0563	0.0563		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	303,673	0	0	303,673	303,673	11.00
11.01	Uncompensated care payments	36.00	736,555	0	568,324	168,231	736,555	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	23,349,265	0	568,324	22,780,941	23,349,265	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	23,349,265	0	568,324	22,780,941	23,349,265	15.00
16.00	Payment for inpatient program capital	50.00	1,779,598	0	71,681	1,707,917	1,779,598	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	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: 150042

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/25/2016 9:57 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	640,005	24,488,858	25,128,863	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	1,707,917	0	0	1,707,917	1,707,917	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	71,681	0	71,681	71,681	143,362	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	1,779,598	0	71,681	1,707,917	1,779,598	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.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 150042		Period: From 01/01/2015 To 12/31/2015		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/25/2016 9:57 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 s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	21,575,303		21,575,303	21,575,303	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	733,734	0	733,734	733,734	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0563	0.0563	0.0563		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	303,673	0	303,673	303,673	11.00
11.01	Uncompensated care payments	36.00	736,555	568,324	168,231	736,555	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	23,349,265	568,324	22,780,941	23,349,265	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	23,349,265	568,324	22,780,941	23,349,265	15.00
16.00	Payment for inpatient program capital	50.00	1,779,598	53,613	1,725,985	1,779,598	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			621,937	24,506,926	25,128,863	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/25/2016 9:57 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	1,707,917	0	1,707,917	1,707,917	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	71,681	53,613	18,068	71,681	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	1,779,598	53,613	1,725,985	1,779,598	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	128,945	0	128,945	128,945	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	-49,620	0	-49,620	-49,620	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		32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/25/2016 9:57 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		59,823	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		25,455,325	2.00
3.00	PPS payments		21,104,109	3.00
4.00	Outlier payment (see instructions)		44,336	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		81,570	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		59,823	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		178,118	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)		178,118	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)		178,118	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		118,295	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)		59,823	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)		21,230,015	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		149	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		4,489,526	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)		16,800,163	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)		16,800,163	30.00
31.00	Primary payer payments		1,271	31.00
32.00	Subtotal (line 30 minus line 31)		16,798,892	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)		603,087	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		392,007	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		482,483	36.00
37.00	Subtotal (see instructions)		17,190,899	37.00
38.00	MSP-LCC reconciliation amount from PS&R		46	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)		17,190,853	40.00
40.01	Sequestration adjustment (see instructions)		343,817	40.01
41.00	Interim payments		16,754,152	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		92,884	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/25/2016 9:57 am
		Component CCN: 15S042	Title XVII I	Subprovider - IPF PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		961	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		498	2.00
3.00	PPS payments		976	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		961	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		2,672	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)		2,672	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)		2,672	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,711	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)		961	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)		976	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)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,937	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)		1,937	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,937	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,937	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)		1,937	40.00
40.01	Sequestration adjustment (see instructions)		39	40.01
41.00	Interim payments		1,480	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		418	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/25/2016 9:57 am
		Component CCN: 15T042	Title XVII I	Subprovider - IRF PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,454	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		332	2.00
3.00	PPS payments		751	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,454	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		4,042	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)		4,042	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)		4,042	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,588	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)		1,454	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)		751	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)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,205	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)		2,205	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,205	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		2,205	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)		2,205	40.00
40.01	Sequestration adjustment (see instructions)		44	40.01
41.00	Interim payments		2,000	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		161	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: 150042

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

Worksheet E-1
Part I
Date/Time Prepared:
5/25/2016 9:57 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		22,145,937		16,714,352	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0	07/17/2015	39,800	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		39,800	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)		22,145,937		16,754,152	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		172,797		92,884	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		22,318,734		16,847,036	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: 150042
Component CCN: 15S042

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

Worksheet E-1
Part I
Date/Time Prepared:
5/25/2016 9:57 am

Title XVIII

Subprovider -
IPF

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					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		1,341,263		1,480	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)		1,341,263		1,480	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		10,727		418	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,351,990		1,898	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: 150042
Component CCN: 15T042

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

Worksheet E-1
Part I
Date/Time Prepared:
5/25/2016 9:57 am

Title XVIII

Subprovider -
IRF

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		9,193,957		2,000	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		9,193,957		2,000	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		32,463		161	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		9,226,420		2,161	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: 150042

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

Worksheet E-1
Part II
Date/Time Prepared:
5/25/2016 9:57 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			6,276 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			13,804 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1,247 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			23,010 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			482,952,627 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			11,242,860 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)			506,528 8.00
9.00	Sequestration adjustment amount (see instructions)			10,131 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			496,397 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			500,354 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)			-3,957 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part II Date/Time Prepared: 5/25/2016 9:57 am
		Component CCN: 15S042	Title XVII I	Subprovider - IPF
		PPS		
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		1,585,555	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	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	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	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	6.00
7.00	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	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		11.558904	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		1,585,555	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		1,585,555	16.00
17.00	Primary payer payments		2,200	17.00
18.00	Subtotal (line 16 less line 17).		1,583,355	18.00
19.00	Deductibles		202,728	19.00
20.00	Subtotal (line 18 minus line 19)		1,380,627	20.00
21.00	Coinsurance		11,970	21.00
22.00	Subtotal (line 20 minus line 21)		1,368,657	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		16,416	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		10,670	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		8,805	25.00
26.00	Subtotal (sum of lines 22 and 24)		1,379,327	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		255	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		1,379,582	31.00
31.01	Sequestration adjustment (see instructions)		27,592	31.01
32.00	Interim payments		1,341,263	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)		10,727	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	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: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part III Date/Time Prepared: 5/25/2016 9:57 am
		Component CCN: 15T042	Title VIII	Subprovider - IRF
		PPS		
		1.00		
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		8,986,784	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0248	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		198,608	3.00
4.00	Outlier Payments		427,486	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)		22.052055	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)		9,612,878	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		9,612,878	17.00
18.00	Primary payer payments		733	18.00
19.00	Subtotal (line 17 less line 18).		9,612,145	19.00
20.00	Deductibles		193,732	20.00
21.00	Subtotal (line 19 minus line 20)		9,418,413	21.00
22.00	Coinsurance		22,050	22.00
23.00	Subtotal (line 21 minus line 22)		9,396,363	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		25,907	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		16,840	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		22,843	26.00
27.00	Subtotal (sum of lines 23 and 25)		9,413,203	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)		1,511	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)		9,414,714	32.00
32.01	Sequestration adjustment (see instructions)		188,294	32.01
33.00	Interim payments		9,193,957	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)		32,463	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		427,486	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

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

Provider CCN: 150042

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

Worksheet G

Date/Time Prepared:
5/25/2016 9:57 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	21,456,548	0	0	0	1.00
2.00	Temporary investments	30,077,030	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	45,796,560	0	0	0	4.00
5.00	Other receivable	5,163,030	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,570,824	0	0	0	6.00
7.00	Inventory	2,010,642	0	0	0	7.00
8.00	Prepaid expenses	3,653,238	0	0	0	8.00
9.00	Other current assets	5,453,581	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)	102,039,805	0	0	0	11.00
FIXED ASSETS						
12.00	Land	7,202,985	0	0	0	12.00
13.00	Land improvements	9,191,361	0	0	0	13.00
14.00	Accumulated depreciation	-4,784,197	0	0	0	14.00
15.00	Buildings	122,958,810	0	0	0	15.00
16.00	Accumulated depreciation	-55,987,375	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	203,683,078	0	0	0	23.00
24.00	Accumulated depreciation	-123,504,841	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	42,627,580	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	201,387,401	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,603,307	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,603,307	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	305,030,513	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	17,628,397	0	0	0	37.00
38.00	Salaries, wages, and fees payable	13,229,426	0	0	0	38.00
39.00	Payroll taxes payable	1,004,459	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,959,161	0	0	0	40.00
41.00	Deferred income	447,302	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	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	34,268,745	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	80,313,219	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	80,313,219	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	114,581,964	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	190,448,549	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	190,448,549	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	305,030,513	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150042

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

Worksheet G-1

Date/Time Prepared:
5/25/2016 9:57 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		195,141,510		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-4,692,961			2.00
3.00	Total (sum of line 1 and line 2)		190,448,549		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		190,448,549		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		190,448,549		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150042

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	18,321,432		18,321,432	1.00
2.00	SUBPROVIDER - IPF	5,742,648		5,742,648	2.00
3.00	SUBPROVIDER - IRF	7,672,355		7,672,355	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	31,736,435		31,736,435	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	15,071,562		15,071,562	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)	15,071,562		15,071,562	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	46,807,997		46,807,997	17.00
18.00	Ancillary services	131,779,153	305,707,032	437,486,185	18.00
19.00	Outpatient services	0	0	0	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	513,627	2,509,369	3,022,996	26.00
27.00	PHYSICIAN OFFICE	13,858,745	45,922,429	59,781,174	27.00
27.01	MH RESIDENTIAL	0	295,082	295,082	27.01
27.02	MOB	1,285	470,702	471,987	27.02
27.03	ASC	90,476	27,041,093	27,131,569	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	193,051,283	381,945,707	574,996,990	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		227,089,520		29.00
30.00	NURSING HOME EXPENSES	72,703,444			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)		72,703,444		36.00
37.00	MISC EXPENSES	432,928			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)		432,928		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		299,360,036		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150042

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

Worksheet G-3

Date/Time Prepared:
5/25/2016 9:57 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	574,996,990	1.00
2.00	Less contractual allowances and discounts on patients' accounts	385,164,526	2.00
3.00	Net patient revenues (line 1 minus line 2)	189,832,464	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	299,360,036	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-109,527,572	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	3,284,798	6.00
7.00	Income from investments	257,528	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	455,437	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	9,875,286	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	NURSING HOME REVENUE	90,961,562	24.00
25.00	Total other income (sum of lines 6-24)	104,834,611	25.00
26.00	Total (line 5 plus line 25)	-4,692,961	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-4,692,961	29.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet K
		Hospice CCN: 151526		Date/Time Prepared: 5/25/2016 9:57 am

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	634,218	177,949	67,911	371,954	77,645	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	877	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	634,218	177,949	67,911	371,954	78,522	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150042

Period: From 01/01/2015

Worksheet K

Hospice CCN: 151526

To 12/31/2015

Date/Time Prepared: 5/25/2016 9:57 am

		Hospice I					
		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	1,329,677	-148,698	1,180,979	-125	1,180,854	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	877	-6,497	-5,620	0	-5,620	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,330,554	-155,195	1,175,359	-125	1,175,234	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150042

Period:

Worksheet K-1

Hospice CCN: 151526

From 01/01/2015
To 12/31/2015

Date/Time Prepared:
5/25/2016 9:57 am

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	634,218	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	634,218	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150042

Period: From 01/01/2015

Worksheet K-1

Hospice CCN: 151526

To 12/31/2015

Date/Time Prepared: 5/25/2016 9:57 am

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	634,218	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	634,218	39.00

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)		Provider CCN: 150042		Period: From 01/01/2015 To 12/31/2015		Worksheet K-2	
		Hospice CCN: 151526				Date/Time Prepared: 5/25/2016 9:57 am	
		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	177,949	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	177,949	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)		Provider CCN: 150042	Period: From 01/01/2015	Worksheet K-2
		Hospice CCN: 151526	To 12/31/2015	Date/Time Prepared: 5/25/2016 9:57 am

		Total Therapists	Aides	All-Other	Hospice I Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	177,949	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	177,949	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet K-3
		Hospice CCN: 151526		Date/Time Prepared: 5/25/2016 9:57 am

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	371,954	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	371,954	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 150042	Period:	Worksheet K-3	
		Hospice CCN: 151526	From 01/01/2015 To 12/31/2015	Date/Time Prepared: 5/25/2016 9:57 am	
		Hospice I			
		Total Therapists	Aides	All-Other	Total (1)
		6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.				1.00
2.00	Capital Related Costs-Movable Equip.				2.00
3.00	Plant Operation and Maintenance		0	0	3.00
4.00	Transportation - Staff		0	0	4.00
5.00	Volunteer Service Coordination		0	0	5.00
6.00	Administrative and General		0	0	6.00
INPATIENT CARE SERVICE					
7.00	Inpatient - General Care		0	0	7.00
8.00	Inpatient - Respite Care		0	0	8.00
VISITING SERVICES					
9.00	Physician Services		0	0	9.00
10.00	Nursing Care		0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	11.00
12.00	Physical Therapy	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	14.00
15.00	Medical Social Services		0	0	15.00
16.00	Spiritual Counseling		0	0	16.00
17.00	Dietary Counseling		0	0	17.00
18.00	Counseling - Other		0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	20.00
21.00	Other		0	0	21.00
OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy				22.00
23.00	Analgesics				23.00
24.00	Sedatives / Hypnotics				24.00
25.00	Other - Specify				25.00
26.00	Durable Medical Equipment/Oxygen				26.00
27.00	Patient Transportation		0	0	27.00
28.00	Imaging Services		0	0	28.00
29.00	Labs and Diagnostics		0	0	29.00
30.00	Medical Supplies		0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	31.00
32.00	Radiation Therapy		0	0	32.00
33.00	Chemotherapy		0	0	33.00
34.00	Other		0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE					
35.00	Bereavement Program Costs		0	0	35.00
36.00	Volunteer Program Costs		0	0	36.00
37.00	Fundraising		0	0	37.00
38.00	Other Program Costs		0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150042
 Hospice CCN: 151526

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

Worksheet K-4
 Part I
 Date/Time Prepared:
 5/25/2016 9:57 am

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	1,180,854	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	-5,620	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,175,234	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST		Provider CCN: 150042	Period: From 01/01/2015	Worksheet K-4
		Hospice CCN: 151526	To 12/31/2015	Part I Date/Time Prepared: 5/25/2016 9:57 am

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	Hospice I	TOTAL (col . 5A ± col . 6)	
		5.00	5A	6.00		7.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	1,180,854	1,180,854			6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	-5,620	1,180,854		1,175,234	7.00
8.00	Inpatient - Respite Care	0	0	0		0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0		0	9.00
10.00	Nursing Care	0	0	0		0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0		0	11.00
12.00	Physical Therapy	0	0	0		0	12.00
13.00	Occupational Therapy	0	0	0		0	13.00
14.00	Speech/ Language Pathology	0	0	0		0	14.00
15.00	Medical Social Services	0	0	0		0	15.00
16.00	Spiritual Counseling	0	0	0		0	16.00
17.00	Dietary Counseling	0	0	0		0	17.00
18.00	Counseling - Other	0	0	0		0	18.00
19.00	Home Health Aide and Homemaker	0	0	0		0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0		0	20.00
21.00	Other	0	0	0		0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0		0	22.00
23.00	Analgesics	0	0	0		0	23.00
24.00	Sedatives / Hypnotics	0	0	0		0	24.00
25.00	Other - Specify	0	0	0		0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0		0	26.00
27.00	Patient Transportation	0	0	0		0	27.00
28.00	Imaging Services	0	0	0		0	28.00
29.00	Labs and Diagnostics	0	0	0		0	29.00
30.00	Medical Supplies	0	0	0		0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0		0	31.00
32.00	Radiation Therapy	0	0	0		0	32.00
33.00	Chemotherapy	0	0	0		0	33.00
34.00	Other	0	0	0		0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0		0	35.00
36.00	Volunteer Program Costs	0	0	0		0	36.00
37.00	Fundraising	0	0	0		0	37.00
38.00	Other Program Costs	0	0	0		0	38.00
39.00	Total (sum of lines 1 thru 38)	0	1,175,234			1,175,234	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150042
Hospice CCN: 151526

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

Worksheet K-4
Part II
Date/Time Prepared:
5/25/2016 9:57 am

		CAPITAL RELATED COST		PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT (\$ VALUE)				
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0	0			3.00
4.00	Transportation - Staff	0	0	0	0		4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150042
Hospice CCN: 151526

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

Worksheet K-4
Part II
Date/Time Prepared:
5/25/2016 9:57 am

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-1,180,854	-5,620	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	-5,620	7.00
8.00	Inpatient - Respite Care	0	0	8.00
VISITING SERVICES				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	0	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		1,180,854	39.00
40.00	Unit Cost Multiplier		-210.116370	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150042

Period:

Worksheet K-5

Hospice CCN: 151526

From 01/01/2015
To 12/31/2015

Part I
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			BLDG & FIXT	MVBLE EQUIP			
			1.00	2.00			
		0	116,930	0	156,592	432	1.00
1.00	Administrative and General		116,930	0	156,592	432	1.00
2.00	Inpatient - General Care	1,175,234	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	1,175,234	116,930	0	156,592	432	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150042

Period:

Worksheet K-5

Hospice CCN: 151526

From 01/01/2015
To 12/31/2015

Part I
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		Hospice I				ADMINISTRATIVE & GENERAL	
		PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal		
		4.02	4.03	4.04	4A.04	5.00	
1.00	Administrative and General	737	6,992	27,936	309,619	36,834	1.00
2.00	Inpatient - General Care	0	0	0	1,175,234	139,812	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	737	6,992	27,936	1,484,853	176,646	34.00
35.00	Unit Cost Multiplier (see instructions)				0.000000		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150042

Period:

Worksheet K-5

Hospice CCN: 151526

From 01/01/2015
To 12/31/2015

Part I
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		Hospice I					
		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	83,227	0	60,827	0	21,172	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	83,227	0	60,827	0	21,172	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150042

Period:

Worksheet K-5

Hospice CCN: 151526

From 01/01/2015
To 12/31/2015

Part I
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		Hospice I					
		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	92,171	629	8	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	92,171	629	8	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150042

Period:

Worksheet K-5

Hospice CCN: 151526

From 01/01/2015
To 12/31/2015

Part I
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		Hospice I				
		MENTAL HEALTH OVERHEAD	PARAMED ED PGRM	PARAMED ED PGRM	Subtotal (col s. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments
		17.01	23.00	23.01	24.00	25.00
1.00	Administrative and General	0	0	0	604,487	1.00
2.00	Inpatient - General Care	0	0	0	1,315,046	0 2.00
3.00	Inpatient - Respite Care	0	0	0	0	0 3.00
4.00	Physician Services	0	0	0	0	0 4.00
5.00	Nursing Care	0	0	0	0	0 5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0 6.00
7.00	Physical Therapy	0	0	0	0	0 7.00
8.00	Occupational Therapy	0	0	0	0	0 8.00
9.00	Speech/ Language Pathology	0	0	0	0	0 9.00
10.00	Medical Social Services	0	0	0	0	0 10.00
11.00	Spiritual Counseling	0	0	0	0	0 11.00
12.00	Dietary Counseling	0	0	0	0	0 12.00
13.00	Counseling - Other	0	0	0	0	0 13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0 14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0 15.00
16.00	Other	0	0	0	0	0 16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0 17.00
18.00	Analgesics	0	0	0	0	0 18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0 19.00
20.00	Other - Specify	0	0	0	0	0 20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0 21.00
22.00	Patient Transportation	0	0	0	0	0 22.00
23.00	Imaging Services	0	0	0	0	0 23.00
24.00	Labs and Diagnostics	0	0	0	0	0 24.00
25.00	Medical Supplies	0	0	0	0	0 25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0 26.00
27.00	Radiation Therapy	0	0	0	0	0 27.00
28.00	Chemotherapy	0	0	0	0	0 28.00
29.00	Other	0	0	0	0	0 29.00
30.00	Bereavement Program Costs	0	0	0	0	0 30.00
31.00	Volunteer Program Costs	0	0	0	0	0 31.00
32.00	Fundraising	0	0	0	0	0 32.00
33.00	Other Program Costs	0	0	0	0	0 33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	1,919,533	0 34.00
35.00	Unit Cost Multiplier (see instructions)					35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150042

Period: From 01/01/2015

Worksheet K-5

Hospice CCN: 151526

To 12/31/2015

Part I
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		Subtotal	Allocated	Total Hospice	Hospice I	
		(col s. 24 ± 25)	Hospice A&G (See Part II)	Costs (col s. 26 ± 27)		
		26.00	27.00	28.00		
1.00	Administrative and General					1.00
2.00	Inpatient - General Care	1,315,046	604,487	1,919,533		2.00
3.00	Inpatient - Respite Care	0	0	0		3.00
4.00	Physician Services	0	0	0		4.00
5.00	Nursing Care	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0		6.00
7.00	Physical Therapy	0	0	0		7.00
8.00	Occupational Therapy	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0		9.00
10.00	Medical Social Services	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0		11.00
12.00	Dietary Counseling	0	0	0		12.00
13.00	Counseling - Other	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0		15.00
16.00	Other	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0		17.00
18.00	Analgesics	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0		19.00
20.00	Other - Specify	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0		21.00
22.00	Patient Transportation	0	0	0		22.00
23.00	Imaging Services	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0		24.00
25.00	Medical Supplies	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0		26.00
27.00	Radiation Therapy	0	0	0		27.00
28.00	Chemotherapy	0	0	0		28.00
29.00	Other	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0		31.00
32.00	Fundraising	0	0	0		32.00
33.00	Other Program Costs	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	1,919,533		1,919,533		34.00
35.00	Unit Cost Multiplier (see instructions)		0.459670			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150042
Hospice CCN: 151526

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

Worksheet K-5
Part II
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
1.00 Administrative and General	4,861	4,861	634,217	3	24,077	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	4,861	4,861	634,217	3	24,077	34.00
35.00 Total cost to be allocated	116,930	0	156,592	432	737	35.00
36.00 Unit Cost Multiplier (see instructions)	24.054721	0.000000	0.246906	144.000000	0.030610	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150042
Hospice CCN: 151526

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

Worksheet K-5
Part II
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		Hospice I					
		REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		4.03	4.04	5A	5.00	7.00	
1.00	Administrative and General	3,022,996	3,022,996	0	309,619	4,861	1.00
2.00	Inpatient - General Care	0	0	0	1,175,234	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	3,022,996	3,022,996		1,484,853	4,861	34.00
35.00	Total cost to be allocated	6,992	27,936		176,646	83,227	35.00
36.00	Unit Cost Multiplier (see instructions)	0.002313	0.009241		0.118965	17.121374	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150042
Hospice CCN: 151526

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

Worksheet K-5
Part II
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		Hospice I					
		LAUNDRY & LINEN SERVICE (LBS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURSING)	
		8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	1,163	0	24,828	24,828	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	1,163	0	24,828	24,828	34.00
35.00	Total cost to be allocated	0	60,827	0	21,172	92,171	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	52.301806	0.000000	0.852747	3.712381	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150042

Hospice CCN: 151526

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

Worksheet K-5
Part II
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		Hospice I					
		CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	MENTAL HEALTH OVERHEAD (CHARGES)	
		14.00	15.00	16.00	17.00	17.01	
1.00	Administrative and General	24,077	22	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	24,077	22	0	0	0	34.00
35.00	Total cost to be allocated	629	8	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.026125	0.363636	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150042

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

Worksheet K-5
Part II
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		PARAMED ED	PARAMED ED	Hospice I	
		PGRM (ASSIGNED TIME)	PGRM (ASSIGNED TIME)		
1.00	Administrative and General	23.00	23.01		1.00
2.00	Inpatient - General Care	0	0		2.00
3.00	Inpatient - Respite Care	0	0		3.00
4.00	Physician Services	0	0		4.00
5.00	Nursing Care	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0		6.00
7.00	Physical Therapy	0	0		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech/ Language Pathology	0	0		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Spiritual Counseling	0	0		11.00
12.00	Dietary Counseling	0	0		12.00
13.00	Counseling - Other	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		15.00
16.00	Other	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		17.00
18.00	Analgesics	0	0		18.00
19.00	Sedatives / Hypnotics	0	0		19.00
20.00	Other - Specify	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0		21.00
22.00	Patient Transportation	0	0		22.00
23.00	Imaging Services	0	0		23.00
24.00	Labs and Diagnostics	0	0		24.00
25.00	Medical Supplies	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		26.00
27.00	Radiation Therapy	0	0		27.00
28.00	Chemotherapy	0	0		28.00
29.00	Other	0	0		29.00
30.00	Bereavement Program Costs	0	0		30.00
31.00	Volunteer Program Costs	0	0		31.00
32.00	Fundraising	0	0		32.00
33.00	Other Program Costs	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0		34.00
35.00	Total cost to be allocated	0	0		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 150042

Period: From 01/01/2015

Worksheet K-5

Hospice CCN: 151526

To 12/31/2015

Part III
Date/Time Prepared:
5/25/2016 9:57 am

Cost Center Description		Hospice I			
		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)
		0	1.00	2.00	3.00
ANCI LLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.164985	0	0
2.00	OCCUPATIONAL THERAPY	67.00		0	0
3.00	SPEECH PATHOLOGY	68.00		0	0
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.359626	0	0
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.297026	0	0
6.00	LABORATORY	60.00	0.138187	0	0
6.01	BLOOD LABORATORY	60.01		0	0
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	1.107165	0	0
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00		0	0
9.00	RADIOLOGY-THERAPEUTIC	55.00		0	0
10.00	MH ANCI LLARY OUTPATIENT	76.00	0.000000	0	0
10.01	INPATIENT DIALYSIS	76.01	0.709855	0	0
11.00	Totals (sum of lines 1-10)				0

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 150042
 Hospice CCN: 151526

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

Worksheet K-6
 Date/Time Prepared:
 5/25/2016 9:57 am

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				1,919,533	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				0	2.00
3.00	Average cost per diem (line 1 divided by line 2)				0.00	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	0				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	0				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			0		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			0		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150042	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/25/2016 9:57 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,707,917	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		71,681	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)		63.35	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)		1,779,598	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