

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: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet S Parts I-III Date/Time Prepared: 11/2/2015 9:47 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 11/2/2015 Time: 9:47 am	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST JOSEPH MEDICAL CENTER (150047) for the cost reporting period beginning 06/01/2014 and ending 05/31/2015 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)

_____ Title

_____ Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-150,759	74,545	-73,576	0	1.00
2.00 Subprovider - IPF	0	6,021	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	1,037	0		0	7.00
200.00 Total	0	-143,701	74,545	-73,576	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: 150047		Period: From 06/01/2014 To 05/31/2015		Worksheet S-2 Part I Date/Time Prepared: 10/30/2015 5:01 pm		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 700 BROADWAY STREET			PO Box:							1.00
2.00	City: FORT WAYNE			State: IN		Zip Code: 46802		County: ALLEN			2.00
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		ST JOSEPH MEDICAL CENTER	150047	23060	1	07/01/1996	N	P	P	3.00
4.00	Subprovider - IPF		ST JOSPEH GENERATIONS	155047	23060	4	06/01/2003	N	P	P	4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF		SKILLED NURSING FACILITY ST JOSEPH	155356	23060		04/01/1990	N	P	N	9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						06/01/2014		05/31/2015		20.00
21.00	Type of Control (see instructions)						4				21.00
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y		N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N		Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N		N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N		N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			3,374	379	18	41	3,463	135	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet S-2 Part I Date/Time Prepared: 10/30/2015 5:01 pm		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00
		V	XVII	XIX		
		1.00	2.00	3.00		
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	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y				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.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

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

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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 67.00
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				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, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)				N N 0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)				N N 0	76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00

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		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
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)				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				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.				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, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	41,855	57,186		0118.01
				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet S-2 Part I Date/Time Prepared: 10/30/2015 5:01 pm	
		1.00	2.00		
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		679005	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: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS, INC.		Contractor's Number: 10301	
142.00	Street: 4000 MERIDIAN BLVD	PO Box:			
143.00	City: FRANKLIN	State: TN		Zip Code: 37067	
		1.00			
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.		Y		145.00
		1.00	2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
					1.00
Multi campus					
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N	165.00
		Name	County	State	Zip Code
		0	1.00	2.00	3.00
		4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)				0.00
					1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act					
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.			Y	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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet S-2 Part I Date/Time Prepared: 10/30/2015 5:01 pm
		Beginning 1.00	Ending 2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	06/01/2014	05/31/2015	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, 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: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet S-2 Part II Date/Time Prepared: 10/30/2015 5:01 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	Y			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	09/10/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet S-2
Part II
Date/Time Prepared:
10/30/2015 5:01 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	1.00 N	2.00	3.00 N	21.00
				1.00	
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			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
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.			N	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.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2014	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LI SA		PARRI SH	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6154657554		LI SA_PARRI SH@CHS. NET	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)	09/10/2015	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
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.	MANGER, REVENUE MANAGEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
10/30/2015 5:01 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	101	32,850	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)		101	32,850	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	6,935	0.00	0	8.00
8.01 NEONATAL INTENSIVE CARE UNIT	31.01	0	0	0.00	0	8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	12	4,380	0.00	0	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)		121	44,165	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	30	10,950		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	21	7,665		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		172				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: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
10/30/2015 5:01 pm

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)	5,369	1,963	25,508			1.00
2.00 HMO and other (see instructions)	3,822	4,348				2.00
3.00 HMO IPF Subprovider	862	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	5,369	1,963	25,508			7.00
8.00 INTENSIVE CARE UNIT	423	81	1,167			8.00
8.01 NEONATAL INTENSIVE CARE UNIT	0	0	0			8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	162	207	1,072			10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		811	1,853			13.00
14.00 Total (see instructions)	5,954	3,062	29,600	5.14	561.51	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	4,052	532	8,539	0.00	13.49	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	1,902	0	4,847	0.00	27.80	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				5.14	602.80	27.00
28.00 Observation Bed Days		0	2,513			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
10/30/2015 5:01 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	1,195	1,273	5,032	1.00
2.00 HMO and other (see instructions)				0	0		2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
8.01 NEONATAL INTENSIVE CARE UNIT							8.01
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	1,195	1,273	5,032	14.00	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0	331	108	715	16.00	16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY	0.00						19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150047		Period: From 06/01/2014 To 05/31/2015		Worksheet S-3 Part II Date/Time Prepared: 10/30/2015 5:01 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	33,385,826	0	33,385,826	1,253,830.00	26.63	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,054,861	0	1,054,861	35,377.00	29.82	9.00
10.00	Excluded area salaries (see instructions)		1,370,739	187,055	1,557,794	64,397.00	24.19	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		89,113	0	89,113	655.00	136.05	13.00
14.00	Home office salaries & wage-related costs		1,830,569	0	1,830,569	29,250.00	62.58	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)		6,162,332	0	6,162,332			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		547,744	0	547,744			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	235,236	0	235,236	7,926.00	29.68	26.00
27.00	Administrative & General	5.00	4,433,456	170,758	4,604,214	179,069.00	25.71	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,010,906	0	1,010,906	48,421.00	20.88	30.00
31.00	Laundry & Linen Service	8.00	2,866	-2,866	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	593,435	0	593,435	51,348.00	11.56	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,804,852	0	1,804,852	54,283.00	33.25	38.00
39.00	Central Services and Supply	14.00	354,947	-354,947	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,401,563	0	1,401,563	35,698.00	39.26	40.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150047		Period: From 06/01/2014 To 05/31/2015		Worksheet S-3 Part II Date/Time Prepared: 10/30/2015 5:01 pm	
	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 466,025	0	466,025	26,066.00	17.88	41.00
42.00	Social Service	17.00 0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet S-3
Part III
Date/Time Prepared:
10/30/2015 5:01 pm

	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	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	33,385,826	0	33,385,826	1,253,830.00	26.63	1.00
2.00	Excluded area salaries (see instructions)	2,425,600	187,055	2,612,655	99,774.00	26.19	2.00
3.00	Subtotal salaries (line 1 minus line 2)	30,960,226	-187,055	30,773,171	1,154,056.00	26.67	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,919,682	0	1,919,682	29,905.00	64.19	4.00
5.00	Subtotal wage-related costs (see inst.)	6,162,332	0	6,162,332	0.00	20.03	5.00
6.00	Total (sum of lines 3 thru 5)	39,042,240	-187,055	38,855,185	1,183,961.00	32.82	6.00
7.00	Total overhead cost (see instructions)	10,303,286	-187,055	10,116,231	402,811.00	25.11	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet S-3 Part IV Date/Time Prepared: 10/30/2015 5:01 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		579,406	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
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)		2,920,356	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		51,829	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		25,184	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		-567	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		15,187	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		531,578	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		1,887,414	17.00
18.00	Medicare Taxes - Employers Portion Only		441,411	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		258,277	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		6,710,075	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		117,195	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet S-3
Part V
Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet S-7

Date/Time Prepared:
10/30/2015 5:01 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
				1.00	2.00
3.00	RUX	140	0	140	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	0	0	0	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	0	0	0	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	35	0	35	14.00
15.00	RVC	157	0	157	15.00
16.00	RVB	208	0	208	16.00
17.00	RVA	264	0	264	17.00
18.00	RHC	146	0	146	18.00
19.00	RHB	245	0	245	19.00
20.00	RHA	503	0	503	20.00
21.00	RMC	61	0	61	21.00
22.00	RMB	37	0	37	22.00
23.00	RMA	44	0	44	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	2	0	2	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	0	0	0	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	0	0	0	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	14	0	14	36.00
37.00	LE2	10	0	10	37.00
38.00	LE1	5	0	5	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	0	0	0	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	0	0	0	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	2	0	2	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	25	0	25	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	0	0	0	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	0	0	0	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet S-7

Date/Time Prepared:
10/30/2015 5:01 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	4	0	4	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,902	0	1,902	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	

201.00	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	23060	23060	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	3,264,400			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet S-10 Date/Time Prepared: 10/30/2015 5:01 pm
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				1.00		
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.167039	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			22,066,460	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	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			0	5.00	
6.00	Medicaid charges			116,267,080	6.00	
7.00	Medicaid cost (line 1 times line 6)			19,421,137	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)			1,135,448	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			9,025,370	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			1,507,589	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)			372,141	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)			372,141	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility			1,318,578	54,620	1,373,198
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)			220,254	9,124	229,378
22.00	Partial payment by patients approved for charity care			393	0	393
23.00	Cost of charity care (line 21 minus line 22)			219,861	9,124	228,985
				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
26.00	Total bad debt expense for the entire hospital complex (see instructions)					25,996,420
27.00	Medicare bad debts for the entire hospital complex (see instructions)					379,041
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)					25,617,379
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)					4,279,101
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)					4,508,086
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)					4,880,227

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet A
Date/Time Prepared:
10/30/2015 5:01 pm

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		1,816,609	1,816,609	1,133,056	2,949,665	1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP		4,539,780	4,539,780	1,377,424	5,917,204	2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	235,236	151,900	387,136	4,234,814	4,621,950	4.00	
5.01 00560 OTHER ADMINISTRATIVE AND GENERAL	4,433,456	49,072,839	53,506,295	-25,223,734	28,282,561	5.01	
5.02 00550 DATA PROCESSING	0	0	0	2,501,822	2,501,822	5.02	
5.03 00591 PURCHASING AND RECEIVING	0	0	0	1,219,079	1,219,079	5.03	
5.04 00540 CENTRAL SCHEDULING	0	0	0	1,195,167	1,195,167	5.04	
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	2,107,075	2,107,075	5.05	
5.06 00590 OTHER ADMINISTRATIVE AND GENERAL	0	0	0	12,666,718	12,666,718	5.06	
7.00 00700 OPERATION OF PLANT	1,010,906	2,668,812	3,679,718	89,584	3,769,302	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	2,866	530,084	532,950	-53,499	479,451	8.00	
9.00 00900 HOUSEKEEPING	593,435	426,005	1,019,440	6,501	1,025,941	9.00	
10.00 01000 DIETARY	0	2,207,585	2,207,585	-1,300,096	907,489	10.00	
11.00 01100 CAFETERIA	0	0	0	1,300,096	1,300,096	11.00	
13.00 01300 NURSING ADMINISTRATION	1,738,752	224,277	1,963,029	221,301	2,184,330	13.00	
13.01 01850 PASTORAL CARE	66,100	23,460	89,560	0	89,560	13.01	
14.00 01400 CENTRAL SERVICES & SUPPLY	354,947	7,319,304	7,674,251	-7,674,251	0	14.00	
15.00 01500 PHARMACY	1,401,563	4,324,160	5,725,723	-3,760,883	1,964,840	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	466,025	324,769	790,794	-646	790,148	16.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	2,700,834	2,700,834	-2,700,834	0	21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	2,700,834	2,700,834	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	6,541,451	2,543,896	9,085,347	-1,699,306	7,386,041	30.00	
31.00 03100 INTENSIVE CARE UNIT	917,103	185,495	1,102,598	0	1,102,598	31.00	
31.01 02060 NEONATAL INTENSIVE CARE UNIT	795,473	193,756	989,229	-989,229	0	31.01	
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	1,697,585	1,697,585	33.00	
40.00 04000 SUBPROVIDER - I PF	1,367,722	211,327	1,579,049	0	1,579,049	40.00	
43.00 04300 NURSERY	0	0	0	989,229	989,229	43.00	
44.00 04400 SKILLED NURSING FACILITY	1,054,861	145,332	1,200,193	0	1,200,193	44.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	1,355,731	1,830,972	3,186,703	-529,608	2,657,095	50.00	
50.01 03330 ENDOSCOPY	0	0	0	527,935	527,935	50.01	
51.00 05100 RECOVERY ROOM	495,708	54,567	550,275	-88	550,187	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	849,509	459,801	1,309,310	-1,429	1,307,881	52.00	
53.00 05300 ANESTHESIOLOGY	0	1,762,802	1,762,802	0	1,762,802	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,210,923	1,224,203	2,435,126	755,896	3,191,022	54.00	
54.01 03630 ULTRA SOUND	334,108	31,923	366,031	-366,031	0	54.01	
56.00 05600 RADIOISOTOPE	92,653	317,236	409,889	-409,889	0	56.00	
57.00 05700 CT SCAN	191,092	41,057	232,149	-232,149	0	57.00	
58.00 05800 MRI	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	1,670,108	1,670,108	59.00	
60.00 06000 LABORATORY	2,027,500	2,261,846	4,289,346	-761,926	3,527,420	60.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	549,704	549,704	62.00	
65.00 06500 RESPIRATORY THERAPY	657,275	195,673	852,948	-28,483	824,465	65.00	
66.00 06600 PHYSICAL THERAPY	584,650	167,687	752,337	-96,595	655,742	66.00	
67.00 06700 OCCUPATIONAL THERAPY	300,845	27,123	327,968	0	327,968	67.00	
68.00 06800 SPEECH PATHOLOGY	73,139	8,100	81,239	0	81,239	68.00	
69.00 06900 ELECTROCARDIOLOGY	921,791	895,194	1,816,985	-1,753,553	63,432	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,826,621	3,826,621	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,320,229	2,320,229	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	3,650,230	3,650,230	73.00	
74.00 07400 RENAL DIALYSIS	0	285,080	285,080	0	285,080	74.00	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00	
76.01 03951 SLEEP LAB	0	0	0	0	0	76.01	
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	349,956	34,461	384,417	0	384,417	76.02	
76.03 03952 WOUND CARE	820,782	183,774	1,004,556	-489	1,004,067	76.03	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	155,657	26,070	181,727	0	181,727	90.00	
91.00 09100 EMERGENCY	1,981,594	664,563	2,646,157	0	2,646,157	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	33,382,809	90,082,356	123,465,165	-841,710	122,623,455	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,017	56,019	59,036	0	59,036	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00	
194.01 07951 MARKETING	0	0	0	841,710	841,710	194.01	
194.02 07952 SENIOR CIRCLE	0	-1,737	-1,737	0	-1,737	194.02	
194.03 07953 SELECT SPECIALTY	0	0	0	0	0	194.03	
194.04 07954 FREE MEALS	0	0	0	0	0	194.04	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet A
Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
200.00 TOTAL (SUM OF LINES 118-199)	33,385,826	90,136,638	123,522,464	0	123,522,464	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet A
Date/Time Prepared:
10/30/2015 5:01 pm

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	3,584,914	6,534,579	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,000,663	4,916,541	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,333	4,619,617	4.00
5.01	00560	OTHER ADMINISTRATIVE AND GENERAL	-28,282,561	0	5.01
5.02	00550	DATA PROCESSING	0	2,501,822	5.02
5.03	00591	PURCHASING AND RECEIVING	0	1,219,079	5.03
5.04	00540	CENTRAL SCHEDULING	0	1,195,167	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	-61,623	2,045,452	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	-1,817,149	10,849,569	5.06
7.00	00700	OPERATION OF PLANT	-27,707	3,741,595	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-12,620	466,831	8.00
9.00	00900	HOUSEKEEPING	0	1,025,941	9.00
10.00	01000	DIETARY	0	907,489	10.00
11.00	01100	CAFETERIA	-166,438	1,133,658	11.00
13.00	01300	NURSING ADMINISTRATION	-4,624	2,179,706	13.00
13.01	01850	PASTORAL CARE	0	89,560	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	1,964,840	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-175	789,973	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	2,700,834	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-936,763	6,449,278	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,102,598	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	-536,425	1,161,160	33.00
40.00	04000	SUBPROVIDER - IPF	3,450	1,582,499	40.00
43.00	04300	NURSERY	-54,542	934,687	43.00
44.00	04400	SKILLED NURSING FACILITY	438	1,200,631	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-636,297	2,020,798	50.00
50.01	03330	ENDOSCOPY	-167,000	360,935	50.01
51.00	05100	RECOVERY ROOM	0	550,187	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-328,050	979,831	52.00
53.00	05300	ANESTHESIOLOGY	-1,760,172	2,630	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,566	3,188,456	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,670,108	59.00
60.00	06000	LABORATORY	0	3,527,420	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	549,704	62.00
65.00	06500	RESPIRATORY THERAPY	0	824,465	65.00
66.00	06600	PHYSICAL THERAPY	-4,292	651,450	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	327,968	67.00
68.00	06800	SPEECH PATHOLOGY	0	81,239	68.00
69.00	06900	ELECTROCARDIOLOGY	0	63,432	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-69	3,826,552	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,320,229	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,650,230	73.00
74.00	07400	RENAL DIALYSIS	0	285,080	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.01	03951	SLEEP LAB	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	384,417	76.02
76.03	03952	WOUND CARE	0	1,004,067	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	181,727	90.00
91.00	09100	EMERGENCY	0	2,646,157	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-32,213,267	90,410,188	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	59,036	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	MARKETING	0	841,710	194.01
194.02	07952	SENIOR CIRCLE	0	-1,737	194.02
194.03	07953	SELECT SPECIALTY	0	0	194.03
194.04	07954	FREE MEALS	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	-32,213,267	91,309,197	200.00

RECLASSIFICATIONS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet A-6
Date/Time Prepared:
10/30/2015 5:01 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,234,814	1.00
	O		0	4,234,814	
B - OXYGEN					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	63,824	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	O		0	63,824	
C - LEASE AND RENTAL					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,363,312	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
	O		0	1,363,312	
D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	147,375	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	985,681	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14,112	3.00
	O		0	1,147,168	
E - MARKETING					
1.00	MARKETING	194.01	187,055	654,655	1.00
	O		187,055	654,655	
F - CNO					
1.00	NURSING ADMINISTRATION	13.00	0	221,840	1.00
	O		0	221,840	
G - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,762,797	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,320,229	2.00
	O		0	6,083,026	
H - DRUGS AND IV COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,650,230	1.00
	O		0	3,650,230	
I - A&G COSTS					
1.00	DATA PROCESSING	5.02	782,923	1,718,899	1.00
2.00	PURCHASING AND RECEIVING	5.03	437,896	781,183	2.00
3.00	CENTRAL SCHEDULING	5.04	1,061,283	133,884	3.00
4.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	279,181	1,827,894	4.00
5.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	2,229,986	16,914,198	5.00
	O		4,791,269	21,376,058	
J - RADIOLOGY					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	617,853	390,216	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	O		617,853	390,216	
K - DIETARY					
1.00	CAFETERIA	11.00	0	1,300,096	1.00
	O		0	1,300,096	
L - MISC DEPARTMENTS					
1.00	BURN INTENSIVE CARE UNIT	33.00	962,904	734,681	1.00
2.00	CARDIAC CATHETERIZATION	59.00	792,576	877,532	2.00
3.00	NURSERY	43.00	795,473	193,756	3.00
4.00	ENDOSCOPY	50.01	206,094	321,841	4.00
5.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	549,704	5.00
	O		2,757,047	2,677,514	

RECLASSIFICATIONS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet A-6

Date/Time Prepared:
10/30/2015 5:01 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
M - UTILITIES RECLASS					
1.00	OPERATION OF PLANT	7.00	0	90,191	1.00
2.00	HOUSEKEEPING	9.00	0	6,501	2.00
3.00		0.00	0	0	3.00
	0		0	96,692	
N - INTERNS AND RESIDENT COSTS					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	2,700,834	1.00
	0		0	2,700,834	
500.00	Grand Total: Increases		8,353,224	45,960,279	500.00

RECLASSIFICATIONS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet A-6
Date/Time Prepared:
10/30/2015 5:01 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - EMPLOYEE BENEFITS							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	4,234,814	0		1.00
	O		0	4,234,814			
B - OXYGEN							
1.00	OPERATION OF PLANT	7.00	0	415	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	34,926	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	28,483	0		3.00
	O		0	63,824			
C - LEASE AND RENTAL							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	31,468	10		1.00
2.00	OPERATION OF PLANT	7.00	0	192	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	284	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	539	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	630,071	0		5.00
6.00	PHARMACY	15.00	0	110,653	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	646	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	1,721	0		8.00
9.00	OPERATING ROOM	50.00	0	120	0		9.00
10.00	RECOVERY ROOM	51.00	0	88	0		10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,429	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	193,350	0		12.00
13.00	LABORATORY	60.00	0	212,222	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	96,595	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	83,445	0		15.00
16.00	WOUND CARE	76.03	0	489	0		16.00
	O		0	1,363,312			
D - OTHER CAPITAL COSTS							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	1,147,168	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	O		0	1,147,168			
E - MARKETING							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	187,055	654,655	0		1.00
	O		187,055	654,655			
F - CNO							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	221,840	0		1.00
	O		0	221,840			
G - MEDICAL SUPPLIES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	6,081,473	0		1.00
2.00	OPERATING ROOM	50.00	0	1,553	0		2.00
	O		0	6,083,026			
H - DRUGS AND IV COSTS							
1.00	PHARMACY	15.00	0	3,650,230	0		1.00
	O		0	3,650,230			
I - A&G COSTS							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	4,433,456	20,790,278	0		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	2,866	12,946	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	354,947	572,834	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	O		4,791,269	21,376,058			
J - RADIOLOGY							
1.00	ULTRA SOUND	54.01	334,108	31,923	0		1.00
2.00	RADIOISOTOPE	56.00	92,653	317,236	0		2.00
3.00	CT SCAN	57.00	191,092	41,057	0		3.00
	O		617,853	390,216			
K - DIETARY							
1.00	DIETARY	10.00	0	1,300,096	0		1.00
	O		0	1,300,096			
L - MISC DEPARTMENTS							
1.00	NEONATAL INTENSIVE CARE UNIT	31.01	795,473	193,756	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	962,904	734,681	0		2.00
3.00	LABORATORY	60.00	0	549,704	0		3.00
4.00	ELECTROCARDIOLOGY	69.00	792,576	877,532	0		4.00
5.00	OPERATING ROOM	50.00	206,094	321,841	0		5.00
	O		2,757,047	2,677,514			

RECLASSIFICATIONS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet A-6

Date/Time Prepared:
10/30/2015 5:01 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
M - UTILITIES RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	466	0	1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	0	37,403	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	58,823	0	3.00
			0	96,692		
N - INTERNS AND RESIDENT COSTS						
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	2,700,834	0	1.00
			0	2,700,834		
500.00	Grand Total: Decreases		8,353,224	45,960,279		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet A-7
Part I
Date/Time Prepared:
10/30/2015 5:01 pm

		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	9,348,028	0	0	0	0	1.00
2.00	Land Improvements	1,759,459	0	0	0	0	2.00
3.00	Buildings and Fixtures	28,316,159	0	0	0	0	3.00
4.00	Building Improvements	23,926,322	3,525,656	0	3,525,656	0	4.00
5.00	Fixed Equipment	17,558,642	62,400	0	62,400	18,327	5.00
6.00	Movable Equipment	49,142,075	1,705,548	0	1,705,548	840,192	6.00
7.00	HIT designated Assets	2,834,603	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	132,885,288	5,293,604	0	5,293,604	858,519	8.00
9.00	Reconciling Items	1,866,808	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	131,018,480	5,293,604	0	5,293,604	858,519	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	9,348,028	0				1.00
2.00	Land Improvements	1,759,459	0				2.00
3.00	Buildings and Fixtures	28,316,159	0				3.00
4.00	Building Improvements	27,451,978	0				4.00
5.00	Fixed Equipment	17,602,715	0				5.00
6.00	Movable Equipment	50,007,431	0				6.00
7.00	HIT designated Assets	2,834,603	0				7.00
8.00	Subtotal (sum of lines 1-7)	137,320,373	0				8.00
9.00	Reconciling Items	1,866,808	0				9.00
10.00	Total (line 8 minus line 9)	135,453,565	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet A-7
Part II
Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,816,609	1,816,609				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,539,780	4,539,780				2.00
3.00	Total (sum of lines 1-2)	6,356,389	6,356,389				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet A-7
Part III
Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,102,673	-57,414	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	-1,000,663	1,363,312	2.00
3.00	Total (sum of lines 1-2)	0	0	0	102,010	1,305,898	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	2,539,655	147,375	985,681	1,816,609	6,534,579	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	14,112	0	4,539,780	4,916,541	2.00
3.00	Total (sum of lines 1-2)	2,539,655	161,487	985,681	6,356,389	11,451,120	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet A-8

Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst. A-7	Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	B	-57,414		CAP REL COSTS-BLDG & FIXT	1.00		10	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-5,904		OTHER ADMINISTRATIVE AND GENERAL	5.06		0	7.00
8.00 Television and radio service (chapter 21)	A	-27,707		OPERATION OF PLANT	7.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-5,301,439					0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-2,361		RADIOLOGY-DIAGNOSTIC	54.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	2,104,782					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-166,438		CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients			0		0.00		0	17.00
18.00 Sale of medical records and abstracts	B	-175		MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines	B	-4,307		OTHER ADMINISTRATIVE AND GENERAL	5.06		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	A	948,507		CAP REL COSTS-BLDG & FIXT	1.00		9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-910,803		CAP REL COSTS-MVBLE EQUIP	2.00		9	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)				ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 INSERVICE EDUCATION REVENUE	B	-3,388		NURSING ADMINISTRATION	13.00		0	33.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.01 FITNESS REVENUE	B	-2,172	OTHER ADMIN STRATIVE AND GENERAL	5.06	0 33.01	
33.02 TELEPHONE COMMISSION	B	-1,080	OTHER ADMIN STRATIVE AND GENERAL	5.06	0 33.02	
33.03 SALE OF SUPPLIES	B	-69	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0 33.03	
33.04 MISC REVENUE	B	-131,397	OTHER ADMIN STRATIVE AND GENERAL	5.06	0 33.04	
33.05 HOSPITAL BAD DEBT	A	-28,282,561	OTHER ADMIN STRATIVE AND GENERAL	5.01	0 33.05	
33.06 PATIENT PHONE WAGE COSTS	A	-11,409	OTHER ADMIN STRATIVE AND GENERAL	5.06	0 33.06	
33.07 PATIENT PHONES BENEFITS	A	-2,333	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.07	
33.08 PATIENT TV DEPRECIATION COSTS	A	-159	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.08	
33.09 PATIENT TV DEPRECIATION	A	-1,511	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.09	
33.10 NONALLOWABLE MARKETING	A	-20,905	OTHER ADMIN STRATIVE AND GENERAL	5.06	0 33.10	
33.11 PHYSICIAN RECRUITING	A	-3,507	OTHER ADMIN STRATIVE AND GENERAL	5.06	0 33.11	
33.12 LOBBYING EXPENSE IN DUES	A	-12,671	OTHER ADMIN STRATIVE AND GENERAL	5.06	0 33.12	
33.13 CHARITABLE CONTRIBUTIONS	A	-82,260	OTHER ADMIN STRATIVE AND GENERAL	5.06	0 33.13	
33.14 PENALTIES	A	-4,292	PHYSICAL THERAPY	66.00	0 33.14	
33.15 IMPUTED RENT	A	-115,315	OTHER ADMIN STRATIVE AND GENERAL	5.06	0 33.15	
33.16 NONALLOWABLE LEGAL EXPENSES (DOJ)	A	-114,979	OTHER ADMIN STRATIVE AND GENERAL	5.06	0 33.16	
33.17		0		0.00	0 33.17	
33.18		0		0.00	0 33.18	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-32,213,267			50.00	

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 150047

Period: From 06/01/2014 To 05/31/2015

Worksheet A-8-1

Date/Time Prepared: 10/30/2015 5:01 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	Direct Allocation - Capital -	2,490,046	0
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	12,096	0
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Moveabl	1,767	0
4.00	5.05	CASHIERING/ACCOUNTS RECEIVAB	PASI Operating Costs	189,316	0
4.01	1.00	CAP REL COSTS-BLDG & FIXT	Pre-Acq. Legacy Capital Cost	5,177	0
4.02	1.00	CAP REL COSTS-BLDG & FIXT	Pre-Acq. Legacy Capital Cost	30,569	0
4.03	5.06	OTHER ADMINISTRATIVE AND GEN	Pre-Acq. Period Non-Capital	317,611	0
4.04	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	20,182	0
4.05	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Movable Equipm	133,984	0
4.06	5.06	OTHER ADMINISTRATIVE AND GEN	Non-Capital Home Office Cost	1,932,998	0
4.07	5.06	OTHER ADMINISTRATIVE AND GEN	Malpractice Costs (See Exhib	99,041	0
4.08	2.00	CAP REL COSTS-MVBLE EQUIP	CIG Leased Equipment (See Ex	239,049	0
4.09	8.00	LAUNDRY & LINEN SERVICE	Hospital Laundry Services (S	447,655	0
4.10	5.06	OTHER ADMINISTRATIVE AND GEN	Management Fees	0	1,558,556
4.11	5.06	OTHER ADMINISTRATIVE AND GEN	401K Fees	0	3,128
4.12	5.06	OTHER ADMINISTRATIVE AND GEN	Audit Fees	0	49,000
4.13	5.06	OTHER ADMINISTRATIVE AND GEN	Corporate overhead allocatio	0	992,205
4.14	5.06	OTHER ADMINISTRATIVE AND GEN	PPSI Fees	0	18,315
4.15	5.05	CASHIERING/ACCOUNTS RECEIVAB	PASI Collection Fees	0	250,939
4.16	5.06	OTHER ADMINISTRATIVE AND GEN	EBOS Fees	0	4,735
4.17	5.06	OTHER ADMINISTRATIVE AND GEN	PASI Lien Unit Collection Fe	0	25,784
4.18	5.06	OTHER ADMINISTRATIVE AND GEN	Malpractice Allocations (Per	0	124,533
4.19	2.00	CAP REL COSTS-MVBLE EQUIP	CIG Leased Equipment (Per Ex	0	327,239
4.20	8.00	LAUNDRY & LINEN SERVICE	Hospital Laundry Services (P	0	460,275
4.21	0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,919,491	3,814,709

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

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

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

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

6.00	B		0.00	CHS, INC	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00	C		33.00	SHARED LAUNDRY	33.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet A-8-1

Date/Time Prepared:
10/30/2015 5:01 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	2,490,046	11		1.00
2.00	12,096	11		2.00
3.00	1,767	11		3.00
4.00	189,316	0		4.00
4.01	5,177	11		4.01
4.02	30,569	11		4.02
4.03	317,611	0		4.03
4.04	20,182	9		4.04
4.05	133,984	9		4.05
4.06	1,932,998	0		4.06
4.07	99,041	0		4.07
4.08	239,049	9		4.08
4.09	447,655	0		4.09
4.10	-1,558,556	0		4.10
4.11	-3,128	0		4.11
4.12	-49,000	0		4.12
4.13	-992,205	0		4.13
4.14	-18,315	0		4.14
4.15	-250,939	0		4.15
4.16	-4,735	0		4.16
4.17	-25,784	0		4.17
4.18	-124,533	0		4.18
4.19	-327,239	9		4.19
4.20	-460,275	0		4.20
4.21	0	0		4.21
5.00	2,104,782			5.00

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

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

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

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

6.00	OWNER		6.00
7.00	DEBT COLLECTION		7.00
8.00	LAUNDRY		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet A-8-2

Date/Time Prepared:
10/30/2015 5:01 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	884,637	884,637	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	1,236	1,236	0	0	0	2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	936,763	936,763	0	0	0	4.00
5.00	33.00	BURN INTENSIVE CARE UNIT	536,425	536,425	0	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	-3,450	-3,450	0	0	0	6.00
7.00	43.00	NURSERY	54,542	54,542	0	0	0	7.00
8.00	44.00	SKILLED NURSING FACILITY	-438	-438	0	0	0	8.00
9.00	50.00	OPERATING ROOM	636,297	636,297	0	0	0	9.00
10.00	50.01	ENDOSCOPY	167,000	167,000	0	0	0	10.00
11.00	52.00	DELIVERY ROOM & LABOR ROOM	328,050	328,050	0	0	0	11.00
12.00	53.00	ANESTHESIOLOGY	1,760,172	1,760,172	0	0	0	12.00
13.00	54.00	RADIOLOGY-DIAGNOSTIC	205	205	0	0	0	13.00
200.00			5,301,439	5,301,439	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	6.00
7.00	43.00	NURSERY	0	0	0	0	0	7.00
8.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	8.00
9.00	50.00	OPERATING ROOM	0	0	0	0	0	9.00
10.00	50.01	ENDOSCOPY	0	0	0	0	0	10.00
11.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	11.00
12.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	12.00
13.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	13.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	884,637		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	1,236		2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	936,763		4.00
5.00	33.00	BURN INTENSIVE CARE UNIT	0	0	0	536,425		5.00
6.00	40.00	SUBPROVIDER - IPF	0	0	0	-3,450		6.00
7.00	43.00	NURSERY	0	0	0	54,542		7.00
8.00	44.00	SKILLED NURSING FACILITY	0	0	0	-438		8.00
9.00	50.00	OPERATING ROOM	0	0	0	636,297		9.00
10.00	50.01	ENDOSCOPY	0	0	0	167,000		10.00
11.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	328,050		11.00
12.00	53.00	ANESTHESIOLOGY	0	0	0	1,760,172		12.00
13.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	205		13.00
200.00			0	0	0	5,301,439		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B
Part I
Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	OTHER ADMINISTRATIVE AND GENERAL	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	6,534,579	6,534,579			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	4,916,541		4,916,541		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,619,617	73,961	55,648	4,749,226	4.00
5.01 00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	5.01
5.02 00550	DATA PROCESSING	2,501,822	210,490	158,370	112,163	5.02
5.03 00591	PURCHASING AND RECEIVING	1,219,079	182,216	137,097	62,734	5.03
5.04 00540	CENTRAL SCHEDULING	1,195,167	51,862	39,021	152,042	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	2,045,452	0	0	39,996	5.05
5.06 00590	OTHER ADMINISTRATIVE AND GENERAL	10,849,569	141,763	106,661	292,674	5.06
7.00 00700	OPERATION OF PLANT	3,741,595	1,112,685	837,168	144,824	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	466,831	58,069	43,690	0	8.00
9.00 00900	HOUSEKEEPING	1,025,941	879,168	661,476	85,017	9.00
10.00 01000	DIETARY	907,489	274,640	206,636	0	10.00
11.00 01100	CAFETERIA	1,133,658	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	2,179,706	31,644	23,809	249,097	13.00
13.01 01850	PASTORAL CARE	89,560	36,550	27,500	9,470	13.01
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	1,964,840	0	0	200,791	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	789,973	164,568	123,819	66,764	16.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,700,834	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,449,278	584,780	439,982	799,199	30.00
31.00 03100	INTENSIVE CARE UNIT	1,102,598	192,826	145,080	131,386	31.00
31.01 02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	31.01
33.00 03300	BURN INTENSIVE CARE UNIT	1,161,160	109,916	82,699	137,948	33.00
40.00 04000	SUBPROVIDER - IPF	1,582,499	83,522	62,841	195,943	40.00
43.00 04300	NURSERY	934,687	43,023	32,370	113,961	43.00
44.00 04400	SKILLED NURSING FACILITY	1,200,631	153,706	115,647	151,121	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,020,798	236,884	178,228	164,699	50.00
50.01 03330	ENDOSCOPY	360,935	32,396	24,375	29,525	50.01
51.00 05100	RECOVERY ROOM	550,187	101,013	76,001	71,016	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	979,831	89,885	67,629	121,702	52.00
53.00 05300	ANESTHESIOLOGY	2,630	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,188,456	258,324	194,360	261,994	54.00
54.01 03630	ULTRA SOUND	0	0	0	0	54.01
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,670,108	28,776	21,651	113,546	59.00
60.00 06000	LABORATORY	3,527,420	221,101	166,354	290,464	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	549,704	12,115	9,115	0	62.00
65.00 06500	RESPIRATORY THERAPY	824,465	89,838	67,593	94,163	65.00
66.00 06600	PHYSICAL THERAPY	651,450	116,733	87,829	83,758	66.00
67.00 06700	OCCUPATIONAL THERAPY	327,968	44,684	33,620	43,100	67.00
68.00 06800	SPEECH PATHOLOGY	81,239	17,209	12,948	10,478	68.00
69.00 06900	ELECTROCARDIOLOGY	63,432	16,378	12,323	18,512	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,826,552	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	2,320,229	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	3,650,230	38,713	29,127	0	73.00
74.00 07400	RENAL DIALYSIS	285,080	31,503	23,702	0	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.01 03951	SLEEP LAB	0	0	0	0	76.01
76.02 03550	PSYCHIATRICAL/PSYCHOLOGICAL SERVICES	384,417	51,063	38,419	50,135	76.02
76.03 03952	WOUND CARE	1,004,067	134,616	101,284	117,587	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	181,727	33,321	25,070	22,300	90.00
91.00 09100	EMERGENCY	2,646,157	206,838	155,623	283,887	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	90,410,188	6,146,779	4,624,765	4,721,996	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	59,036	15,861	11,934	432	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	MARKETING	841,710	0	0	26,798	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B
Part I
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	OTHER ADMINISTRATIVE AND GENERAL	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
194.02 07952 SENIOR CIRCLE	-1,737	0	0	0	0	0 194.02
194.03 07953 SELECT SPECIALTY	0	371,939	279,842	0	0	0 194.03
194.04 07954 FREE MEALS	0	0	0	0	0	0 194.04
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118-201)	91,309,197	6,534,579	4,916,541	4,749,226	0	0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150047

Period:
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To 05/31/2015

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Cost Center Description			DATA PROCESSING	PURCHASING AND RECEIVING	CENTRAL SCHEDULING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING	2,982,845					5.02
5.03	00591	PURCHASING AND RECEIVING	0	1,601,126				5.03
5.04	00540	CENTRAL SCHEDULING	0	0	1,438,092			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	2,085,448		5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	11,390,667	5.06
7.00	00700	OPERATION OF PLANT	0	0	0	0	5,836,272	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	568,590	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	2,651,602	9.00
10.00	01000	DIETARY	0	0	0	0	1,388,765	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,133,658	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	2,484,256	13.00
13.01	01850	PASTORAL CARE	0	0	0	0	163,080	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	23,461	0	0	2,189,092	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	735	0	0	1,145,859	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	2,700,834	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	239,789	63,432	115,597	167,653	8,859,710	30.00
31.00	03100	INTENSIVE CARE UNIT	21,602	11,005	10,414	15,103	1,630,014	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	37,615	19,075	18,134	26,299	1,592,846	33.00
40.00	04000	SUBPROVIDER - IPF	119,410	6,592	57,565	83,488	2,191,860	40.00
43.00	04300	NURSERY	19,881	11,490	9,584	13,900	1,178,896	43.00
44.00	04400	SKILLED NURSING FACILITY	19,218	7,337	9,264	13,436	1,670,360	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	237,056	100,877	114,280	165,742	3,218,564	50.00
50.01	03330	ENDOSCOPY	25,628	17,693	12,355	17,918	520,825	50.01
51.00	05100	RECOVERY ROOM	27,533	2,201	13,273	19,250	860,474	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,466	10,565	4,563	6,618	1,290,259	52.00
53.00	05300	ANESTHESIOLOGY	34,432	15	16,599	24,074	77,750	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	443,697	6,164	214,021	310,159	4,877,175	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	125,932	87,794	60,709	88,048	2,196,564	59.00
60.00	06000	LABORATORY	356,405	68,213	171,815	249,187	5,050,959	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	21,971	4,718	10,592	15,361	623,576	62.00
65.00	06500	RESPIRATORY THERAPY	84,023	17,731	40,506	58,746	1,277,065	65.00
66.00	06600	PHYSICAL THERAPY	30,482	1,447	14,695	21,312	1,007,706	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,061	166	9,189	13,327	491,115	67.00
68.00	06800	SPEECH PATHOLOGY	4,360	179	2,102	3,048	131,563	68.00
69.00	06900	ELECTROCARDIOLOGY	18,907	1,032	9,115	13,219	152,918	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	94,060	639,085	45,344	65,764	4,670,805	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	217,275	394,077	104,744	151,912	3,188,237	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	409,761	0	197,537	286,492	4,611,860	73.00
74.00	07400	RENAL DIALYSIS	14,103	612	6,799	9,860	371,659	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	33,497	892	16,148	23,420	597,991	76.02
76.03	03952	WOUND CARE	40,544	18,955	19,546	28,347	1,464,946	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	552	2,249	266	386	265,871	90.00
91.00	09100	EMERGENCY	276,585	73,598	133,336	193,379	3,969,403	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,982,845	1,591,390	1,438,092	2,085,448	89,693,646	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,943	0	0	96,206	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	793	0	0	869,301	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	-1,737	194.02
194.03	07953	SELECT SPECIALTY	0	0	0	0	651,781	194.03
194.04	07954	FREE MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

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Cost Center Description		DATA PROCESSING	PURCHASING AND RECEIVING	CENTRAL SCHEDULING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
		5.02	5.03	5.04	5.05	5A.05	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,982,845	1,601,126	1,438,092	2,085,448	91,309,197	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150047

Period:
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To 05/31/2015

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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.06	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00560	OTHER ADMINISTRATIVE AND GENERAL					5.01	
5.02	00550	DATA PROCESSING					5.02	
5.03	00591	PURCHASING AND RECEIVING					5.03	
5.04	00540	CENTRAL SCHEDULING					5.04	
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05	
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	11,390,667				5.06	
7.00	00700	OPERATION OF PLANT	831,815	6,668,087			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	81,038	81,319	730,947		8.00	
9.00	00900	HOUSEKEEPING	377,920	1,231,177	0	4,260,699	9.00	
10.00	01000	DIETARY	197,934	384,602	0	305,975	2,277,276	10.00
11.00	01100	CAFETERIA	161,575	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	354,069	44,314	0	35,254	0	13.00
13.01	01850	PASTORAL CARE	23,243	51,184	0	40,720	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	312,000	0	973	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	163,314	230,459	0	183,344	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	384,936	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,262,762	818,918	288,502	651,499	939,907	30.00
31.00	03100	INTENSIVE CARE UNIT	232,318	270,032	16,596	214,826	43,000	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	227,020	153,924	0	122,456	39,499	33.00
40.00	04000	SUBPROVIDER - I/PF	312,395	116,963	64,789	93,051	314,637	40.00
43.00	04300	NURSERY	168,022	60,248	11,963	47,931	0	43.00
44.00	04400	SKILLED NURSING FACILITY	238,068	215,248	36,883	171,243	178,594	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	458,726	331,729	38,655	263,910	0	50.00
50.01	03330	ENDOSCOPY	74,231	45,367	0	36,093	0	50.01
51.00	05100	RECOVERY ROOM	122,639	141,458	12,885	112,538	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	183,894	125,874	0	100,141	0	52.00
53.00	05300	ANESTHESIOLOGY	11,081	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	695,119	361,754	60,865	287,797	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	313,065	40,297	0	32,059	0	59.00
60.00	06000	LABORATORY	719,888	309,627	2,768	246,327	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	88,875	16,966	0	13,498	0	62.00
65.00	06500	RESPIRATORY THERAPY	182,014	125,808	0	100,088	0	65.00
66.00	06600	PHYSICAL THERAPY	143,623	163,472	1,182	130,052	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	69,996	62,575	0	49,782	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,751	24,099	0	19,173	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,795	22,936	3,383	18,247	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	665,706	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	454,403	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	657,305	54,213	0	43,129	0	73.00
74.00	07400	RENAL DIALYSIS	52,971	44,116	6,135	35,097	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	85,229	71,508	0	56,889	0	76.02
76.03	03952	WOUND CARE	208,791	188,515	43,475	149,975	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	37,893	46,662	79	37,123	0	90.00
91.00	09100	EMERGENCY	565,739	289,653	141,814	230,437	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,160,163	6,125,017	730,947	3,828,654	1,515,637	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,712	22,212	0	17,671	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	304,297	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	123,897	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	SELECT SPECIALTY	92,895	520,858	0	414,374	284,134	194.03
194.04	07954	FREE MEALS	0	0	0	0	173,208	194.04
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150047

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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.06	7.00	8.00	9.00	10.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	11,390,667	6,668,087	730,947	4,260,699	2,277,276	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150047

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PASTORAL CARE	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	13.00	13.01	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00560						5.01
5.02	00550						5.02
5.03	00591						5.03
5.04	00540						5.04
5.05	00580						5.05
5.06	00590						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,295,233					11.00
13.00	01300	73,261	2,991,154				13.00
13.01	01850	4,210	0	282,437			13.01
14.00	01400	0	0	0	0		14.00
15.00	01500	48,167	0	0	0	2,550,232	15.00
16.00	01600	35,171	0	0	0	0	16.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	278,869	1,091,665	103,079	0	0	30.00
31.00	03100	37,866	148,228	13,996	0	0	31.00
31.01	02060	0	0	0	0	0	31.01
33.00	03300	46,595	182,438	17,227	0	0	33.00
40.00	04000	78,033	0	0	0	0	40.00
43.00	04300	31,999	125,313	11,833	0	0	43.00
44.00	04400	47,746	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	57,570	225,322	21,276	0	0	50.00
50.01	03330	7,719	30,206	2,852	0	0	50.01
51.00	05100	23,915	93,607	8,839	0	0	51.00
52.00	05200	37,866	148,276	14,001	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	94,734	0	0	0	0	54.00
54.01	03630	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	33,066	129,459	12,224	0	0	59.00
60.00	06000	110,172	431,320	40,727	0	0	60.00
62.00	06200	0	0	0	0	0	62.00
65.00	06500	32,757	0	0	0	0	65.00
66.00	06600	25,627	0	0	0	0	66.00
67.00	06700	9,965	0	0	0	0	67.00
68.00	06800	2,667	0	0	2,667	0	68.00
69.00	06900	5,866	0	0	0	0	69.00
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	2,550,232	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	0	0	0	0	0	76.01
76.02	03550	18,021	0	0	0	0	76.02
76.03	03952	37,501	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	8,561	0	0	0	0	90.00
91.00	09100	98,439	385,320	36,383	0	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		1,286,363	2,991,154	282,437	0	2,550,232	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	337	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	8,533	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B
Part I
Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PASTORAL CARE	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	13.00	13.01	14.00	15.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,295,233	2,991,154	282,437	0	2,550,232	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B
Part I
Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
	16.00	21.00	22.00	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
5.01 00560 OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02 00550 DATA PROCESSING						5.02
5.03 00591 PURCHASING AND RECEIVING						5.03
5.04 00540 CENTRAL SCHEDULING						5.04
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 00590 OTHER ADMINISTRATIVE AND GENERAL						5.06
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
13.01 01850 PASTORAL CARE						13.01
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1,758,147					16.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV		0	0			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV			3,085,770			22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	141,340	0	455,852	14,892,103	-455,852	30.00
31.00 03100 INTENSIVE CARE UNIT	12,733	0	0	2,619,609	0	31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
33.00 03300 BURN INTENSIVE CARE UNIT	22,172	0	0	2,404,177	0	33.00
40.00 04000 SUBPROVIDER - IPF	70,385	0	0	3,242,113	0	40.00
43.00 04300 NURSERY	11,719	0	0	1,647,924	0	43.00
44.00 04400 SKILLED NURSING FACILITY	11,327	0	0	2,569,469	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	139,729	0	683,779	5,439,260	-683,779	50.00
50.01 03330 ENDOSCOPY	15,106	0	0	732,399	0	50.01
51.00 05100 RECOVERY ROOM	16,229	0	0	1,392,584	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	5,579	0	0	1,905,890	0	52.00
53.00 05300 ANESTHESIOLOGY	20,296	0	0	109,127	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	261,486	0	0	6,638,930	0	54.00
54.01 03630 ULTRA SOUND	0	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	74,229	0	0	2,830,963	0	59.00
60.00 06000 LABORATORY	210,077	0	0	7,121,865	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	12,950	0	0	755,865	0	62.00
65.00 06500 RESPIRATORY THERAPY	49,526	0	0	1,767,258	0	65.00
66.00 06600 PHYSICAL THERAPY	17,967	0	0	1,489,629	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	11,235	0	0	694,668	0	67.00
68.00 06800 SPEECH PATHOLOGY	2,570	0	0	198,823	0	68.00
69.00 06900 ELECTROCARDIOLOGY	11,145	0	0	236,290	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	55,442	0	0	5,391,953	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	128,069	0	0	3,770,709	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	241,527	0	0	8,158,266	0	73.00
74.00 07400 RENAL DIALYSIS	8,313	0	0	518,291	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01 03951 SLEEP LAB	0	0	0	0	0	76.01
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	19,744	0	0	849,382	0	76.02
76.03 03952 WOUND CARE	23,898	0	35,066	2,152,167	-35,066	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	325	0	1,718,212	2,114,726	-1,718,212	90.00
91.00 09100 EMERGENCY	163,029	0	0	5,880,217	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,758,147	0	2,892,909	87,524,657	-2,892,909	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	150,138	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	192,861	497,158	-192,861	192.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07951 MARKETING	0	0	0	1,001,731	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B
Part I
Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
	16.00	21.00	22.00	24.00	25.00	
194.02 07952 SENIOR CIRCLE	0	0	0	-1,737	0	194.02
194.03 07953 SELECT SPECIALTY	0	0	0	1,964,042	0	194.03
194.04 07954 FREE MEALS	0	0	0	173,208	0	194.04
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	1,758,147	0	3,085,770	91,309,197	-3,085,770	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B
Part I
Date/Time Prepared:
10/30/2015 5:01 pm

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
5.01	00560 OTHER ADMINISTRATIVE AND GENERAL		5.01
5.02	00550 DATA PROCESSING		5.02
5.03	00591 PURCHASING AND RECEIVING		5.03
5.04	00540 CENTRAL SCHEDULING		5.04
5.05	00580 CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL		5.06
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
13.01	01850 PASTORAL CARE		13.01
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	14,436,251	30.00
31.00	03100 INTENSIVE CARE UNIT	2,619,609	31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT	0	31.01
33.00	03300 BURN INTENSIVE CARE UNIT	2,404,177	33.00
40.00	04000 SUBPROVIDER - I PF	3,242,113	40.00
43.00	04300 NURSERY	1,647,924	43.00
44.00	04400 SKILLED NURSING FACILITY	2,569,469	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	4,755,481	50.00
50.01	03330 ENDOSCOPY	732,399	50.01
51.00	05100 RECOVERY ROOM	1,392,584	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,905,890	52.00
53.00	05300 ANESTHESIOLOGY	109,127	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,638,930	54.00
54.01	03630 ULTRA SOUND	0	54.01
56.00	05600 RADIOISOTOPE	0	56.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MRI	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	2,830,963	59.00
60.00	06000 LABORATORY	7,121,865	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	755,865	62.00
65.00	06500 RESPIRATORY THERAPY	1,767,258	65.00
66.00	06600 PHYSICAL THERAPY	1,489,629	66.00
67.00	06700 OCCUPATIONAL THERAPY	694,668	67.00
68.00	06800 SPEECH PATHOLOGY	198,823	68.00
69.00	06900 ELECTROCARDIOLOGY	236,290	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,391,953	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,770,709	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,158,266	73.00
74.00	07400 RENAL DIALYSIS	518,291	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	76.00
76.01	03951 SLEEP LAB	0	76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	849,382	76.02
76.03	03952 WOUND CARE	2,117,101	76.03
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	396,514	90.00
91.00	09100 EMERGENCY	5,880,217	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	84,631,748	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	150,138	190.00
191.00	19100 RESEARCH	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	304,297	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07951 MARKETING	1,001,731	194.01
194.02	07952 SENIOR CIRCLE	-1,737	194.02
194.03	07953 SELECT SPECIALTY	1,964,042	194.03
194.04	07954 FREE MEALS	173,208	194.04
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	88,223,427	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B
Part II
Date/Time Prepared:
10/30/2015 5:01 pm

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	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	73,961	55,648	129,609	129,609 4.00
5.01 00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0 5.01
5.02 00550	DATA PROCESSING	0	210,490	158,370	368,860	3,061 5.02
5.03 00591	PURCHASING AND RECEIVING	0	182,216	137,097	319,313	1,712 5.03
5.04 00540	CENTRAL SCHEDULING	0	51,862	39,021	90,883	4,150 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	1,092 5.05
5.06 00590	OTHER ADMINISTRATIVE AND GENERAL	0	141,763	106,661	248,424	7,988 5.06
7.00 00700	OPERATION OF PLANT	0	1,112,685	837,168	1,949,853	3,953 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	58,069	43,690	101,759	0 8.00
9.00 00900	HOUSEKEEPING	0	879,168	661,476	1,540,644	2,320 9.00
10.00 01000	DIETARY	0	274,640	206,636	481,276	0 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	0	31,644	23,809	55,453	6,799 13.00
13.01 01850	PASTORAL CARE	0	36,550	27,500	64,050	258 13.01
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00 01500	PHARMACY	0	0	0	0	5,480 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	164,568	123,819	288,387	1,822 16.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	584,780	439,982	1,024,762	21,801 30.00
31.00 03100	INTENSIVE CARE UNIT	0	192,826	145,080	337,906	3,586 31.00
31.01 02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0 31.01
33.00 03300	BURN INTENSIVE CARE UNIT	0	109,916	82,699	192,615	3,765 33.00
40.00 04000	SUBPROVIDER - I PF	0	83,522	62,841	146,363	5,348 40.00
43.00 04300	NURSERY	0	43,023	32,370	75,393	3,110 43.00
44.00 04400	SKILLED NURSING FACILITY	0	153,706	115,647	269,353	4,125 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	236,884	178,228	415,112	4,495 50.00
50.01 03330	ENDOSCOPY	0	32,396	24,375	56,771	806 50.01
51.00 05100	RECOVERY ROOM	0	101,013	76,001	177,014	1,938 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	89,885	67,629	157,514	3,322 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	258,324	194,360	452,684	7,151 54.00
54.01 03630	ULTRA SOUND	0	0	0	0	0 54.01
56.00 05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MRI	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	28,776	21,651	50,427	3,099 59.00
60.00 06000	LABORATORY	0	221,101	166,354	387,455	7,928 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	12,115	9,115	21,230	0 62.00
65.00 06500	RESPIRATORY THERAPY	0	89,838	67,593	157,431	2,570 65.00
66.00 06600	PHYSICAL THERAPY	0	116,733	87,829	204,562	2,286 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	44,684	33,620	78,304	1,176 67.00
68.00 06800	SPEECH PATHOLOGY	0	17,209	12,948	30,157	286 68.00
69.00 06900	ELECTROCARDIOLOGY	0	16,378	12,323	28,701	505 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	38,713	29,127	67,840	0 73.00
74.00 07400	RENAL DIALYSIS	0	31,503	23,702	55,205	0 74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0 76.00
76.01 03951	SLEEP LAB	0	0	0	0	0 76.01
76.02 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	51,063	38,419	89,482	1,368 76.02
76.03 03952	WOUND CARE	0	134,616	101,284	235,900	3,209 76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	33,321	25,070	58,391	609 90.00
91.00 09100	EMERGENCY	0	206,838	155,623	362,461	7,748 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	6,146,779	4,624,765	10,771,544	128,866 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,861	11,934	27,795	12 190.00
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
194.01 07951	MARKETING	0	0	0	0	731 194.01
194.02 07952	SENIOR CIRCLE	0	0	0	0	0 194.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
	0			2A	4.00	
194.03 07953 SELECT SPECIALTY	0	371,939	279,842	651,781		0 194.03
194.04 07954 FREE MEALS	0	0	0	0		0 194.04
200.00 Cross Foot Adjustments				0		0 200.00
201.00 Negative Cost Centers		0	0	0		0 201.00
202.00 TOTAL (sum lines 118-201)	0	6,534,579	4,916,541	11,451,120	129,609	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150047

Period:
From 06/01/2014
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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	DATA PROCESSING	PURCHASING AND RECEIVING	CENTRAL SCHEDULING	CASHIERING/ACC OUNTS RECEIVABLE	
		5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	OTHER ADMINISTRATIVE AND GENERAL	0				5.01
5.02	00550	DATA PROCESSING	371,921				5.02
5.03	00591	PURCHASING AND RECEIVING	0	321,025			5.03
5.04	00540	CENTRAL SCHEDULING	0	0	95,033		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	1,092	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	5.06
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
13.01	01850	PASTORAL CARE	0	0	0	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	4,704	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	147	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	29,897	12,718	7,658	81
31.00	03100	INTENSIVE CARE UNIT	0	2,693	2,206	690	7
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	4,690	3,825	1,201	13
40.00	04000	SUBPROVIDER - I PF	0	14,888	1,322	3,813	41
43.00	04300	NURSERY	0	2,479	2,304	635	7
44.00	04400	SKILLED NURSING FACILITY	0	2,396	1,471	614	7
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	29,556	20,226	7,570	81
50.01	03330	ENDOSCOPY	0	3,195	3,547	818	9
51.00	05100	RECOVERY ROOM	0	3,433	441	879	9
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,180	2,118	302	3
53.00	05300	ANESTHESIOLOGY	0	4,293	3	1,100	12
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	55,339	1,236	13,944	230
54.01	03630	ULTRA SOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	15,701	17,603	4,022	43
60.00	06000	LABORATORY	0	44,437	13,677	11,382	121
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,739	946	702	7
65.00	06500	RESPIRATORY THERAPY	0	10,476	3,555	2,683	29
66.00	06600	PHYSICAL THERAPY	0	3,801	290	973	10
67.00	06700	OCCUPATIONAL THERAPY	0	2,376	33	609	6
68.00	06800	SPEECH PATHOLOGY	0	544	36	139	1
69.00	06900	ELECTROCARDIOLOGY	0	2,357	207	604	6
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,728	128,135	3,004	32
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,090	79,013	6,939	74
73.00	07300	DRUGS CHARGED TO PATIENTS	0	51,090	0	13,086	139
74.00	07400	RENAL DIALYSIS	0	1,758	123	450	5
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0
76.01	03951	SLEEP LAB	0	0	0	0	0
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	4,176	179	1,070	11
76.03	03952	WOUND CARE	0	5,055	3,800	1,295	14
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	69	451	18	0
91.00	09100	EMERGENCY	0	34,485	14,757	8,833	94
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	371,921	319,073	95,033	1,092
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,793	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	MARKETING	0	0	159	0	0
194.02	07952	SENIOR CIRCLE	0	0	0	0	0
194.03	07953	SELECT SPECIALTY	0	0	0	0	0
194.04	07954	FREE MEALS	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	DATA PROCESSING	PURCHASING AND RECEIVING	CENTRAL SCHEDULING	CASHIERING/ACC OUNTS RECEIVABLE	
		5.01	5.02	5.03	5.04	5.05	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	371,921	321,025	95,033	1,092	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet B Part II Date/Time Prepared: 10/30/2015 5:01 pm		
Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00591	PURCHASING AND RECEIVING					5.03
5.04	00540	CENTRAL SCHEDULING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	256,412				5.06
7.00	00700	OPERATION OF PLANT	18,723	1,972,529			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,824	24,055	127,638		8.00
9.00	00900	HOUSEKEEPING	8,506	364,202	0	1,915,672	9.00
10.00	01000	DIETARY	4,455	113,772	0	137,571	737,074 10.00
11.00	01100	CAFETERIA	3,637	0	0	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	7,969	13,109	0	15,851	0 13.00
13.01	01850	PASTORAL CARE	523	15,141	0	18,308	0 13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00	01500	PHARMACY	7,023	0	170	0	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,676	68,173	0	82,434	0 16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	8,664	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	28,450	242,249	50,378	292,922	304,215 30.00
31.00	03100	INTENSIVE CARE UNIT	5,229	79,880	2,898	96,589	13,918 31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0 31.01
33.00	03300	BURN INTENSIVE CARE UNIT	5,110	45,533	0	55,058	12,784 33.00
40.00	04000	SUBPROVIDER - I/PF	7,031	34,600	11,313	41,837	101,837 40.00
43.00	04300	NURSERY	3,782	17,822	2,089	21,551	0 43.00
44.00	04400	SKILLED NURSING FACILITY	5,359	63,674	6,441	76,993	57,805 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,325	98,131	6,750	118,658	0 50.00
50.01	03330	ENDOSCOPY	1,671	13,420	0	16,228	0 50.01
51.00	05100	RECOVERY ROOM	2,760	41,845	2,250	50,599	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,139	37,236	0	45,025	0 52.00
53.00	05300	ANESTHESIOLOGY	249	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,646	107,013	10,628	129,398	0 54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0 54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	7,047	11,921	0	14,414	0 59.00
60.00	06000	LABORATORY	16,203	91,593	483	110,752	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,000	5,019	0	6,069	0 62.00
65.00	06500	RESPIRATORY THERAPY	4,097	37,216	0	45,001	0 65.00
66.00	06600	PHYSICAL THERAPY	3,233	48,358	206	58,473	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	1,575	18,511	0	22,383	0 67.00
68.00	06800	SPEECH PATHOLOGY	422	7,129	0	8,620	0 68.00
69.00	06900	ELECTROCARDIOLOGY	491	6,785	591	8,204	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,984	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,228	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,795	16,037	0	19,392	0 73.00
74.00	07400	RENAL DIALYSIS	1,192	13,050	1,071	15,780	0 74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0 76.00
76.01	03951	SLEEP LAB	0	0	0	0	0 76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,918	21,153	0	25,578	0 76.02
76.03	03952	WOUND CARE	4,700	55,766	7,592	67,431	0 76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	853	13,803	14	16,691	0 90.00
91.00	09100	EMERGENCY	12,734	85,684	24,764	103,608	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	251,223	1,811,880	127,638	1,721,418	490,559 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	309	6,571	0	7,945	0 190.00
191.00	19100	RESEARCH	0	0	0	0	0 191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	98,490 192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
194.01	07951	MARKETING	2,789	0	0	0	0 194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0 194.02
194.03	07953	SELECT SPECIALTY	2,091	154,078	0	186,309	91,964 194.03
194.04	07954	FREE MEALS	0	0	0	0	56,061 194.04
200.00		Cross Foot Adjustments					200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150047			Period: From 06/01/2014 To 05/31/2015		Worksheet B Part II Date/Time Prepared: 10/30/2015 5:01 pm	
Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	256,412	1,972,529	127,638	1,915,672	737,074		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PASTORAL CARE	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	13.00	13.01	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00560						5.01
5.02	00550						5.02
5.03	00591						5.03
5.04	00540						5.04
5.05	00580						5.05
5.06	00590						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	3,637					11.00
13.00	01300	206	99,387				13.00
13.01	01850	12	0	98,292			13.01
14.00	01400	0	0	0	0		14.00
15.00	01500	135	0	0	0	17,512	15.00
16.00	01600	99	0	0	0	0	16.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	784	36,272	35,873	0	0	30.00
31.00	03100	106	4,925	4,871	0	0	31.00
31.01	02060	0	0	0	0	0	31.01
33.00	03300	131	6,062	5,995	0	0	33.00
40.00	04000	219	0	0	0	0	40.00
43.00	04300	90	4,164	4,118	0	0	43.00
44.00	04400	134	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	162	7,487	7,404	0	0	50.00
50.01	03330	22	1,004	993	0	0	50.01
51.00	05100	67	3,110	3,076	0	0	51.00
52.00	05200	106	4,927	4,872	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	266	0	0	0	0	54.00
54.01	03630	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	93	4,302	4,254	0	0	59.00
60.00	06000	309	14,331	14,174	0	0	60.00
62.00	06200	0	0	0	0	0	62.00
65.00	06500	92	0	0	0	0	65.00
66.00	06600	72	0	0	0	0	66.00
67.00	06700	28	0	0	0	0	67.00
68.00	06800	7	0	0	0	0	68.00
69.00	06900	16	0	0	0	0	69.00
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	0	73.00
74.00	07400	0	0	0	0	17,512	74.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	0	0	0	0	0	76.01
76.02	03550	51	0	0	0	0	76.02
76.03	03952	105	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	24	0	0	0	0	90.00
91.00	09100	276	12,803	12,662	0	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		3,612	99,387	98,292	0	17,512	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	24	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150047			Period: From 06/01/2014 To 05/31/2015		Worksheet B Part II Date/Time Prepared: 10/30/2015 5:01 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PASTORAL CARE	CENTRAL SERVICES & SUPPLY	PHARMACY		
		11.00	13.00	13.01	14.00	15.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	3,637	99,387	98,292	0	17,512	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150047

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Cost Center Description	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
		16.00	21.00		
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00560 OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02 00550 DATA PROCESSING					5.02
5.03 00591 PURCHASING AND RECEIVING					5.03
5.04 00540 CENTRAL SCHEDULING					5.04
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 00590 OTHER ADMINISTRATIVE AND GENERAL					5.06
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
13.01 01850 PASTORAL CARE					13.01
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15.00 01500 PHARMACY					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	444,738				16.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0		8,664		22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS	35,763			2,123,823	0 30.00
31.00 03100 INTENSIVE CARE UNIT	3,222			558,726	0 31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0			0	0 31.01
33.00 03300 BURN INTENSIVE CARE UNIT	5,610			342,392	0 33.00
40.00 04000 SUBPROVIDER - IPF	17,809			386,421	0 40.00
43.00 04300 NURSERY	2,965			140,509	0 43.00
44.00 04400 SKILLED NURSING FACILITY	2,866			491,238	0 44.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	35,355			761,312	0 50.00
50.01 03330 ENDOSCOPY	3,822			102,306	0 50.01
51.00 05100 RECOVERY ROOM	4,106			291,527	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1,412			262,156	0 52.00
53.00 05300 ANESTHESIOLOGY	5,135			10,792	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	66,044			859,579	0 54.00
54.01 03630 ULTRA SOUND	0			0	0 54.01
56.00 05600 RADIOISOTOPE	0			0	0 56.00
57.00 05700 CT SCAN	0			0	0 57.00
58.00 05800 MRI	0			0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	18,782			151,708	0 59.00
60.00 06000 LABORATORY	53,155			766,000	0 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	3,277			41,989	0 62.00
65.00 06500 RESPIRATORY THERAPY	12,531			275,681	0 65.00
66.00 06600 PHYSICAL THERAPY	4,546			326,810	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	2,843			127,844	0 67.00
68.00 06800 SPEECH PATHOLOGY	650			47,991	0 68.00
69.00 06900 ELECTROCARDIOLOGY	2,820			51,287	0 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	14,028			171,911	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	32,405			155,749	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	61,113			261,004	0 73.00
74.00 07400 RENAL DIALYSIS	2,103			90,737	0 74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0			0	0 76.00
76.01 03951 SLEEP LAB	0			0	0 76.01
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,996			149,982	0 76.02
76.03 03952 WOUND CARE	6,047			390,914	0 76.03
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	82			91,005	0 90.00
91.00 09100 EMERGENCY	41,251			722,160	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1-117)	444,738	0	0	10,153,553	0 118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			44,426	0 190.00
191.00 19100 RESEARCH	0			0	0 191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0			98,490	0 192.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0			0	0 194.00
194.01 07951 MARKETING	0			3,703	0 194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B
Part II
Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
	16.00	21.00	22.00	24.00	25.00	
194.02 07952 SENIOR CIRCLE	0			0	0	194.02
194.03 07953 SELECT SPECIALTY	0			1,086,223	0	194.03
194.04 07954 FREE MEALS	0			56,061	0	194.04
200.00 Cross Foot Adjustments		0	8,664	8,664	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	444,738	0	8,664	11,451,120	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet B Part II Date/Time Prepared: 10/30/2015 5:01 pm
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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
5.01	00560 OTHER ADMINISTRATIVE AND GENERAL		5.01
5.02	00550 DATA PROCESSING		5.02
5.03	00591 PURCHASING AND RECEIVING		5.03
5.04	00540 CENTRAL SCHEDULING		5.04
5.05	00580 CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL		5.06
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
13.01	01850 PASTORAL CARE		13.01
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	2,123,823	30.00
31.00	03100 INTENSIVE CARE UNIT	558,726	31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT	0	31.01
33.00	03300 BURN INTENSIVE CARE UNIT	342,392	33.00
40.00	04000 SUBPROVIDER - I PF	386,421	40.00
43.00	04300 NURSERY	140,509	43.00
44.00	04400 SKILLED NURSING FACILITY	491,238	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	761,312	50.00
50.01	03330 ENDOSCOPY	102,306	50.01
51.00	05100 RECOVERY ROOM	291,527	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	262,156	52.00
53.00	05300 ANESTHESIOLOGY	10,792	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	859,579	54.00
54.01	03630 ULTRA SOUND	0	54.01
56.00	05600 RADIOISOTOPE	0	56.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MRI	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	151,708	59.00
60.00	06000 LABORATORY	766,000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	41,989	62.00
65.00	06500 RESPIRATORY THERAPY	275,681	65.00
66.00	06600 PHYSICAL THERAPY	326,810	66.00
67.00	06700 OCCUPATIONAL THERAPY	127,844	67.00
68.00	06800 SPEECH PATHOLOGY	47,991	68.00
69.00	06900 ELECTROCARDIOLOGY	51,287	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	171,911	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	155,749	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	261,004	73.00
74.00	07400 RENAL DIALYSIS	90,737	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	76.00
76.01	03951 SLEEP LAB	0	76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	149,982	76.02
76.03	03952 WOUND CARE	390,914	76.03
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	91,005	90.00
91.00	09100 EMERGENCY	722,160	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,153,553	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	44,426	190.00
191.00	19100 RESEARCH	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	98,490	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07951 MARKETING	3,703	194.01
194.02	07952 SENIOR CIRCLE	0	194.02
194.03	07953 SELECT SPECIALTY	1,086,223	194.03
194.04	07954 FREE MEALS	56,061	194.04
200.00	Cross Foot Adjustments	8,664	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	11,451,120	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B-1

Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	DATA PROCESSING (GROSS CHARGES)	
		BLDG & FIXT (SQUARE FOOTAGE)	MVBLE EQUIP (SQUARE FOOTAGE)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	416,929				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		416,929			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,719	4,719	33,150,590		4.00
5.01	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	13,430	13,430	782,923	506,659,878	5.02
5.03	00591	PURCHASING AND RECEIVING	11,626	11,626	437,896	0	5.03
5.04	00540	CENTRAL SCHEDULING	3,309	3,309	1,061,283	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	279,181	0	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	9,045	9,045	2,042,931	0	5.06
7.00	00700	OPERATION OF PLANT	70,993	70,993	1,010,906	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,705	3,705	0	0	8.00
9.00	00900	HOUSEKEEPING	56,094	56,094	593,435	0	9.00
10.00	01000	DIETARY	17,523	17,523	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,019	2,019	1,738,752	0	13.00
13.01	01850	PASTORAL CARE	2,332	2,332	66,100	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	1,401,563	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,500	10,500	466,025	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	37,311	37,311	5,578,547	40,731,948	30.00
31.00	03100	INTENSIVE CARE UNIT	12,303	12,303	917,103	3,669,384	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	7,013	7,013	962,904	6,389,552	33.00
40.00	04000	SUBPROVIDER - IPF	5,329	5,329	1,367,722	20,283,754	40.00
43.00	04300	NURSERY	2,745	2,745	795,473	3,377,102	43.00
44.00	04400	SKILLED NURSING FACILITY	9,807	9,807	1,054,861	3,264,400	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	15,114	15,114	1,149,637	40,267,709	50.00
50.01	03330	ENDOSCOPY	2,067	2,067	206,094	4,353,242	50.01
51.00	05100	RECOVERY ROOM	6,445	6,445	495,708	4,676,866	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,735	5,735	849,509	1,607,871	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,848,900	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,482	16,482	1,828,776	75,345,733	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,836	1,836	792,576	21,391,562	59.00
60.00	06000	LABORATORY	14,107	14,107	2,027,500	60,540,956	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	773	773	0	3,732,086	62.00
65.00	06500	RESPIRATORY THERAPY	5,732	5,732	657,275	14,272,596	65.00
66.00	06600	PHYSICAL THERAPY	7,448	7,448	584,650	5,177,835	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,851	2,851	300,845	3,237,736	67.00
68.00	06800	SPEECH PATHOLOGY	1,098	1,098	73,139	740,554	68.00
69.00	06900	ELECTROCARDIOLOGY	1,045	1,045	129,215	3,211,701	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	15,977,588	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,907,635	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,470	2,470	0	69,604,391	73.00
74.00	07400	RENAL DIALYSIS	2,010	2,010	0	2,395,600	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	76.01
76.02	03550	PSYCHIATRICAL/PSYCHOLOGICAL SERVICES	3,258	3,258	349,956	5,689,966	76.02
76.03	03952	WOUND CARE	8,589	8,589	820,782	6,887,112	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,126	2,126	155,657	93,747	90.00
91.00	09100	EMERGENCY	13,197	13,197	1,981,594	46,982,352	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	392,186	392,186	32,960,518	506,659,878	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,012	1,012	3,017	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	187,055	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B-1

Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	DATA PROCESSING (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FOOTAGE)	MVBLE EQUIP (SQUARE FOOTAGE)				
	1.00	2.00				
194.02 07952 SENIOR CIRCLE	0	0	0	0	0	194.02
194.03 07953 SELECT SPECIALTY	23,731	23,731	0	0	0	194.03
194.04 07954 FREE MEALS	0	0	0	0	0	194.04
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	6,534,579	4,916,541	4,749,226	0	2,982,845	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	15.673122	11.792274	0.143262	0.000000	0.005887	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			129,609	0	371,921	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.003910	0.000000	0.000734	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B-1
Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description			PURCHASING AND RECEIVING (COSTED REQ S)	CENTRAL SCHEDULING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00591	PURCHASING AND RECEIVING	9,427,060					5.03
5.04	00540	CENTRAL SCHEDULING	0	506,659,878				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	506,659,878			5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	-11,390,667	79,920,267	5.06
7.00	00700	OPERATION OF PLANT	0	0	0	0	5,836,272	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	568,590	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	2,651,602	9.00
10.00	01000	DIETARY	0	0	0	0	1,388,765	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,133,658	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	2,484,256	13.00
13.01	01850	PASTORAL CARE	0	0	0	0	163,080	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	138,132	0	0	0	2,189,092	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,326	0	0	0	1,145,859	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	2,700,834	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	373,471	40,731,948	40,731,948	0	8,859,710	30.00
31.00	03100	INTENSIVE CARE UNIT	64,792	3,669,384	3,669,384	0	1,630,014	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	112,307	6,389,552	6,389,552	0	1,592,846	33.00
40.00	04000	SUBPROVIDER - I PF	38,811	20,283,754	20,283,754	0	2,191,860	40.00
43.00	04300	NURSERY	67,651	3,377,102	3,377,102	0	1,178,896	43.00
44.00	04400	SKILLED NURSING FACILITY	43,201	3,264,400	3,264,400	0	1,670,360	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	593,940	40,267,709	40,267,709	0	3,218,564	50.00
50.01	03330	ENDOSCOPY	104,172	4,353,242	4,353,242	0	520,825	50.01
51.00	05100	RECOVERY ROOM	12,957	4,676,866	4,676,866	0	860,474	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	62,203	1,607,871	1,607,871	0	1,290,259	52.00
53.00	05300	ANESTHESIOLOGY	88	5,848,900	5,848,900	0	77,750	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,291	75,345,733	75,345,733	0	4,877,175	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	516,911	21,391,562	21,391,562	0	2,196,564	59.00
60.00	06000	LABORATORY	401,623	60,540,956	60,540,956	0	5,050,959	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	27,780	3,732,086	3,732,086	0	623,576	62.00
65.00	06500	RESPIRATORY THERAPY	104,396	14,272,596	14,272,596	0	1,277,065	65.00
66.00	06600	PHYSICAL THERAPY	8,522	5,177,835	5,177,835	0	1,007,706	66.00
67.00	06700	OCCUPATIONAL THERAPY	978	3,237,736	3,237,736	0	491,115	67.00
68.00	06800	SPEECH PATHOLOGY	1,051	740,554	740,554	0	131,563	68.00
69.00	06900	ELECTROCARDIOLOGY	6,078	3,211,701	3,211,701	0	152,918	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,762,798	15,977,588	15,977,588	0	4,670,805	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,320,229	36,907,635	36,907,635	0	3,188,237	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	69,604,391	69,604,391	0	4,611,860	73.00
74.00	07400	RENAL DIALYSIS	3,602	2,395,600	2,395,600	0	371,659	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,251	5,689,966	5,689,966	0	597,991	76.02
76.03	03952	WOUND CARE	111,602	6,887,112	6,887,112	0	1,464,946	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	13,243	93,747	93,747	0	265,871	90.00
91.00	09100	EMERGENCY	433,328	46,982,352	46,982,352	0	3,969,403	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,369,734	506,659,878	506,659,878	-11,390,667	78,302,979	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	52,657	0	0	0	96,206	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	4,669	0	0	0	869,301	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	1,737	0	194.02
194.03	07953	SELECT SPECIALTY	0	0	0	0	651,781	194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B-1

Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description			PURCHASING AND RECEIVING (COSTED REQ S)	CENTRAL SCHEDULING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
194.04	07954	FREE MEALS	0	0	0	0	0	194.04
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)	1,601,126	1,438,092	2,085,448		11,390,667	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.169844	0.002838	0.004116		0.142525	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	321,025	95,033	1,092		256,412	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.034054	0.000188	0.000002		0.003208	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B-1

Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FOOTAGE)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FOOTAGE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)		
		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	
5.01	00560	OTHER ADMINISTRATIVE AND GENERAL					5.01	
5.02	00550	DATA PROCESSING					5.02	
5.03	00591	PURCHASING AND RECEIVING					5.03	
5.04	00540	CENTRAL SCHEDULING					5.04	
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05	
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL					5.06	
7.00	00700	OPERATION OF PLANT	303,807				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	3,705	871,729			8.00	
9.00	00900	HOUSEKEEPING	56,094	0	244,008		9.00	
10.00	01000	DIETARY	17,523	0	17,523	167,830	10.00	
11.00	01100	CAFETERIA	0	0	0	46,144	11.00	
13.00	01300	NURSING ADMINISTRATION	2,019	0	2,019	0	13.00	
13.01	01850	PASTORAL CARE	2,332	0	2,332	0	13.01	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00	
15.00	01500	PHARMACY	0	1,160	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	10,500	0	10,500	0	16.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	37,311	344,068	37,311	69,269	9,935	30.00
31.00	03100	INTENSIVE CARE UNIT	12,303	19,793	12,303	3,169	1,349	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	7,013	0	7,013	2,911	1,660	33.00
40.00	04000	SUBPROVIDER - IPF	5,329	77,267	5,329	23,188	2,780	40.00
43.00	04300	NURSERY	2,745	14,267	2,745	0	1,140	43.00
44.00	04400	SKILLED NURSING FACILITY	9,807	43,987	9,807	13,162	1,701	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,114	46,100	15,114	0	2,051	50.00
50.01	03330	ENDOSCOPY	2,067	0	2,067	0	275	50.01
51.00	05100	RECOVERY ROOM	6,445	15,367	6,445	0	852	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,735	0	5,735	0	1,349	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,482	72,588	16,482	0	3,375	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,836	0	1,836	0	1,178	59.00
60.00	06000	LABORATORY	14,107	3,301	14,107	0	3,925	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	773	0	773	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	5,732	0	5,732	0	1,167	65.00
66.00	06600	PHYSICAL THERAPY	7,448	1,410	7,448	0	913	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,851	0	2,851	0	355	67.00
68.00	06800	SPEECH PATHOLOGY	1,098	0	1,098	0	95	68.00
69.00	06900	ELECTROCARDIOLOGY	1,045	4,034	1,045	0	209	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,470	0	2,470	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,010	7,317	2,010	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,258	0	3,258	0	642	76.02
76.03	03952	WOUND CARE	8,589	51,848	8,589	0	1,336	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,126	94	2,126	0	305	90.00
91.00	09100	EMERGENCY	13,197	169,128	13,197	0	3,507	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	279,064	871,729	219,265	111,699	45,828	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,012	0	1,012	0	12	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	22,426	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	304	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	SELECT SPECIALTY	23,731	0	23,731	20,940	0	194.03
194.04	07954	FREE MEALS	0	0	0	12,765	0	194.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B-1

Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FOOTAGE)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FOOTAGE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
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)	6,668,087	730,947	4,260,699	2,277,276	1,295,233	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	21.948431	0.838503	17.461309	13.568945	28.069370	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,972,529	127,638	1,915,672	737,074	3,637	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	6.492704	0.146419	7.850857	4.391789	0.078818	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSNG HRS)	PASTORAL CARE (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
		13.00	13.01	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00560						5.01
5.02	00550						5.02
5.03	00591						5.03
5.04	00540						5.04
5.05	00580						5.05
5.06	00590						5.06
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	566,233					13.00
13.01	01850	0	566,233				13.01
14.00	01400	0	0	0			14.00
15.00	01500	0	0	0	3,650,230		15.00
16.00	01600	0	0	0	0	506,659,878	16.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	206,655	206,655	0	0	40,731,948	30.00
31.00	03100	28,060	28,060	0	0	3,669,384	31.00
31.01	02060	0	0	0	0	0	31.01
33.00	03300	34,536	34,536	0	0	6,389,552	33.00
40.00	04000	0	0	0	0	20,283,754	40.00
43.00	04300	23,722	23,722	0	0	3,377,102	43.00
44.00	04400	0	0	0	0	3,264,400	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	42,654	42,654	0	0	40,267,709	50.00
50.01	03330	5,718	5,718	0	0	4,353,242	50.01
51.00	05100	17,720	17,720	0	0	4,676,866	51.00
52.00	05200	28,069	28,069	0	0	1,607,871	52.00
53.00	05300	0	0	0	0	5,848,900	53.00
54.00	05400	0	0	0	0	75,345,733	54.00
54.01	03630	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	24,507	24,507	0	0	21,391,562	59.00
60.00	06000	81,650	81,650	0	0	60,540,956	60.00
62.00	06200	0	0	0	0	3,732,086	62.00
65.00	06500	0	0	0	0	14,272,596	65.00
66.00	06600	0	0	0	0	5,177,835	66.00
67.00	06700	0	0	0	0	3,237,736	67.00
68.00	06800	0	0	0	0	740,554	68.00
69.00	06900	0	0	0	0	3,211,701	69.00
71.00	07100	0	0	0	0	15,977,588	71.00
72.00	07200	0	0	0	0	36,907,635	72.00
73.00	07300	0	0	0	3,650,230	69,604,391	73.00
74.00	07400	0	0	0	0	2,395,600	74.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	0	0	0	0	0	76.01
76.02	03550	0	0	0	0	5,689,966	76.02
76.03	03952	0	0	0	0	6,887,112	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	93,747	90.00
91.00	09100	72,942	72,942	0	0	46,982,352	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		566,233	566,233	0	3,650,230	506,659,878	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B-1

Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSING HRS)	PASTORAL CARE (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
			13.00	13.01	14.00	15.00	16.00	
194.04	07954	FREE MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,991,154	282,437	0	2,550,232	1,758,147	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.282550	0.498800	0.000000	0.698650	0.003470	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	99,387	98,292	0	17,512	444,738	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.175523	0.173589	0.000000	0.004798	0.000878	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B-1

Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description	INTERNS & RESIDENTS			
	SERVICES-SALARY & FRINGES APPRV (ROTATIONS)	SERVICES-OTHER PRGM COSTS APPRV (ROTATIONS)		
	21.00	22.00		
GENERAL SERVICE COST CENTERS				
1.00 00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01 00560	OTHER ADMINISTRATIVE AND GENERAL			5.01
5.02 00550	DATA PROCESSING			5.02
5.03 00591	PURCHASING AND RECEIVING			5.03
5.04 00540	CENTRAL SCHEDULING			5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE			5.05
5.06 00590	OTHER ADMINISTRATIVE AND GENERAL			5.06
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
13.01 01850	PASTORAL CARE			13.01
14.00 01400	CENTRAL SERVICES & SUPPLY			14.00
15.00 01500	PHARMACY			15.00
16.00 01600	MEDICAL RECORDS & LIBRARY			16.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	8,800		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV		8,800	22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000	ADULTS & PEDIATRICS	1,300	1,300	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	31.00
31.01 02060	NEONATAL INTENSIVE CARE UNIT	0	0	31.01
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	33.00
40.00 04000	SUBPROVIDER - IPF	0	0	40.00
43.00 04300	NURSERY	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000	OPERATING ROOM	1,950	1,950	50.00
50.01 03330	ENDOSCOPY	0	0	50.01
51.00 05100	RECOVERY ROOM	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 03630	ULTRA SOUND	0	0	54.01
56.00 05600	RADIOISOTOPE	0	0	56.00
57.00 05700	CT SCAN	0	0	57.00
58.00 05800	MRI	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000	LABORATORY	0	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.01 03951	SLEEP LAB	0	0	76.01
76.02 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.02
76.03 03952	WOUND CARE	100	100	76.03
OUTPATIENT SERVICE COST CENTERS				
90.00 09000	CLINIC	4,900	4,900	90.00
91.00 09100	EMERGENCY	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	8,250	8,250	118.00
NONREIMBURSABLE COST CENTERS				
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00 19100	RESEARCH	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	550	550	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01 07951	MARKETING	0	0	194.01
194.02 07952	SENIOR CIRCLE	0	0	194.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet B-1

Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description	INTERNS & RESIDENTS			
	SERVICES-SALARY & FRINGES APPRV (ROTATIONS)	SERVICES-OTHER PRGM COSTS APPRV (ROTATIONS)		
	21.00	22.00		
194.03 07953 SELECT SPECIALTY	0	0		194.03
194.04 07954 FREE MEALS	0	0		194.04
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)	0	3,085,770		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	350.655682		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	8,664		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	0.984545		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet C
Part I
Date/Time Prepared:
10/30/2015 5:01 pm

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	14,436,251		14,436,251	0	14,436,251	30.00
31.00	03100 INTENSIVE CARE UNIT	2,619,609		2,619,609	0	2,619,609	31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT	0		0	0	0	31.01
33.00	03300 BURN INTENSIVE CARE UNIT	2,404,177		2,404,177	0	2,404,177	33.00
40.00	04000 SUBPROVIDER - IPF	3,242,113		3,242,113	0	3,242,113	40.00
43.00	04300 NURSERY	1,647,924		1,647,924	0	1,647,924	43.00
44.00	04400 SKILLED NURSING FACILITY	2,569,469		2,569,469	0	2,569,469	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4,755,481		4,755,481	0	4,755,481	50.00
50.01	03330 ENDOSCOPY	732,399		732,399	0	732,399	50.01
51.00	05100 RECOVERY ROOM	1,392,584		1,392,584	0	1,392,584	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,905,890		1,905,890	0	1,905,890	52.00
53.00	05300 ANESTHESIOLOGY	109,127		109,127	0	109,127	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,638,930		6,638,930	0	6,638,930	54.00
54.01	03630 ULTRA SOUND	0		0	0	0	54.01
56.00	05600 RADIOISOTOPE	0		0	0	0	56.00
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MRI	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	2,830,963		2,830,963	0	2,830,963	59.00
60.00	06000 LABORATORY	7,121,865		7,121,865	0	7,121,865	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	755,865		755,865	0	755,865	62.00
65.00	06500 RESPIRATORY THERAPY	1,767,258	0	1,767,258	0	1,767,258	65.00
66.00	06600 PHYSICAL THERAPY	1,489,629	0	1,489,629	0	1,489,629	66.00
67.00	06700 OCCUPATIONAL THERAPY	694,668	0	694,668	0	694,668	67.00
68.00	06800 SPEECH PATHOLOGY	198,823	0	198,823	0	198,823	68.00
69.00	06900 ELECTROCARDIOLOGY	236,290		236,290	0	236,290	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,391,953		5,391,953	0	5,391,953	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,770,709		3,770,709	0	3,770,709	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,158,266		8,158,266	0	8,158,266	73.00
74.00	07400 RENAL DIALYSIS	518,291		518,291	0	518,291	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.01	03951 SLEEP LAB	0		0	0	0	76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	849,382		849,382	0	849,382	76.02
76.03	03952 WOUND CARE	2,117,101		2,117,101	0	2,117,101	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	396,514		396,514	0	396,514	90.00
91.00	09100 EMERGENCY	5,880,217		5,880,217	0	5,880,217	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,294,672		1,294,672	0	1,294,672	92.00
200.00	Subtotal (see instructions)	85,926,420	0	85,926,420	0	85,926,420	200.00
201.00	Less Observation Beds	1,294,672		1,294,672	0	1,294,672	201.00
202.00	Total (see instructions)	84,631,748	0	84,631,748	0	84,631,748	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150047		Period: From 06/01/2014 To 05/31/2015		Worksheet C Part I Date/Time Prepared: 10/30/2015 5:01 pm	
			Title XVII I		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	35,458,401		35,458,401			30.00
31.00	03100	INTENSIVE CARE UNIT	3,669,384		3,669,384			31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0		0			31.01
33.00	03300	BURN INTENSIVE CARE UNIT	6,389,552		6,389,552			33.00
40.00	04000	SUBPROVIDER - I PF	20,283,754		20,283,754			40.00
43.00	04300	NURSERY	3,377,102		3,377,102			43.00
44.00	04400	SKILLED NURSING FACILITY	3,264,400		3,264,400			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,000,624	19,267,085	40,267,709	0.118097	0.000000	50.00
50.01	03330	ENDOSCOPY	1,229,000	3,124,242	4,353,242	0.168242	0.000000	50.01
51.00	05100	RECOVERY ROOM	1,912,621	2,764,245	4,676,866	0.297760	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,127,325	480,546	1,607,871	1.185350	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,526,353	2,322,547	5,848,900	0.018658	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,894,083	54,451,650	75,345,733	0.088113	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,506,885	10,884,677	21,391,562	0.132340	0.000000	59.00
60.00	06000	LABORATORY	30,565,750	29,975,206	60,540,956	0.117637	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,583,489	148,597	3,732,086	0.202532	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	12,898,893	1,373,703	14,272,596	0.123822	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,032,867	3,144,968	5,177,835	0.287693	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,916,473	321,263	3,237,736	0.214554	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	486,016	254,538	740,554	0.268479	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	600,000	2,611,701	3,211,701	0.073572	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,849,911	9,127,677	15,977,588	0.337470	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,578,104	17,329,531	36,907,635	0.102166	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,929,703	13,674,688	69,604,391	0.117209	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,369,910	25,690	2,395,600	0.216351	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,664,187	3,025,779	5,689,966	0.149277	0.000000	76.02
76.03	03952	WOUND CARE	1,817,476	5,069,636	6,887,112	0.307400	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,604	89,143	93,747	4.229618	0.000000	90.00
91.00	09100	EMERGENCY	8,363,492	38,618,860	46,982,352	0.125158	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	744,948	4,528,599	5,273,547	0.245503	0.000000	92.00
200.00		Subtotal (see instructions)	284,045,307	222,614,571	506,659,878			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	284,045,307	222,614,571	506,659,878			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet C Part I Date/Time Prepared: 10/30/2015 5:01 pm
		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
31.01	02060 NEONATAL INTENSIVE CARE UNIT			31.01
33.00	03300 BURN INTENSIVE CARE UNIT			33.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.118097		50.00
50.01	03330 ENDOSCOPY	0.168242		50.01
51.00	05100 RECOVERY ROOM	0.297760		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.185350		52.00
53.00	05300 ANESTHESIOLOGY	0.018658		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.088113		54.00
54.01	03630 ULTRA SOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.132340		59.00
60.00	06000 LABORATORY	0.117637		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.202532		62.00
65.00	06500 RESPIRATORY THERAPY	0.123822		65.00
66.00	06600 PHYSICAL THERAPY	0.287693		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.214554		67.00
68.00	06800 SPEECH PATHOLOGY	0.268479		68.00
69.00	06900 ELECTROCARDIOLOGY	0.073572		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.337470		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.102166		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.117209		73.00
74.00	07400 RENAL DIALYSIS	0.216351		74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000		76.00
76.01	03951 SLEEP LAB	0.000000		76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.149277		76.02
76.03	03952 WOUND CARE	0.307400		76.03
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	4.229618		90.00
91.00	09100 EMERGENCY	0.125158		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.245503		92.00
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: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet C Part I Date/Time Prepared: 10/30/2015 5:01 pm
		Title XIX	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		14,436,251	0	14,436,251	30.00
31.00	03100 INTENSIVE CARE UNIT		2,619,609	0	2,619,609	31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT		0	0	0	31.01
33.00	03300 BURN INTENSIVE CARE UNIT		2,404,177	0	2,404,177	33.00
40.00	04000 SUBPROVIDER - IPF		3,242,113	0	3,242,113	40.00
43.00	04300 NURSERY		1,647,924	0	1,647,924	43.00
44.00	04400 SKILLED NURSING FACILITY		2,569,469	0	2,569,469	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		4,755,481	0	4,755,481	50.00
50.01	03330 ENDOSCOPY		732,399	0	732,399	50.01
51.00	05100 RECOVERY ROOM		1,392,584	0	1,392,584	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,905,890	0	1,905,890	52.00
53.00	05300 ANESTHESIOLOGY		109,127	0	109,127	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		6,638,930	0	6,638,930	54.00
54.01	03630 ULTRA SOUND		0	0	0	54.01
56.00	05600 RADIOISOTOPE		0	0	0	56.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MRI		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		2,830,963	0	2,830,963	59.00
60.00	06000 LABORATORY		7,121,865	0	7,121,865	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		755,865	0	755,865	62.00
65.00	06500 RESPIRATORY THERAPY	0	1,767,258	0	1,767,258	65.00
66.00	06600 PHYSICAL THERAPY	0	1,489,629	0	1,489,629	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	694,668	0	694,668	67.00
68.00	06800 SPEECH PATHOLOGY	0	198,823	0	198,823	68.00
69.00	06900 ELECTROCARDIOLOGY		236,290	0	236,290	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		5,391,953	0	5,391,953	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		3,770,709	0	3,770,709	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		8,158,266	0	8,158,266	73.00
74.00	07400 RENAL DIALYSIS		518,291	0	518,291	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER		0	0	0	76.00
76.01	03951 SLEEP LAB		0	0	0	76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		849,382	0	849,382	76.02
76.03	03952 WOUND CARE		2,117,101	0	2,117,101	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		396,514	0	396,514	90.00
91.00	09100 EMERGENCY		5,880,217	0	5,880,217	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,294,672	0	1,294,672	92.00
200.00	Subtotal (see instructions)	0	85,926,420	0	85,926,420	200.00
201.00	Less Observation Beds		1,294,672	0	1,294,672	201.00
202.00	Total (see instructions)	0	84,631,748	0	84,631,748	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150047		Period: From 06/01/2014 To 05/31/2015		Worksheet C Part I Date/Time Prepared: 10/30/2015 5:01 pm	
			Title XIX		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	35,458,401		35,458,401			30.00
31.00	03100	INTENSIVE CARE UNIT	3,669,384		3,669,384			31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0		0			31.01
33.00	03300	BURN INTENSIVE CARE UNIT	6,389,552		6,389,552			33.00
40.00	04000	SUBPROVIDER - I/PF	20,283,754		20,283,754			40.00
43.00	04300	NURSERY	3,377,102		3,377,102			43.00
44.00	04400	SKILLED NURSING FACILITY	3,264,400		3,264,400			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,000,624	19,267,085	40,267,709	0.118097	0.000000	50.00
50.01	03330	ENDOSCOPY	1,229,000	3,124,242	4,353,242	0.168242	0.000000	50.01
51.00	05100	RECOVERY ROOM	1,912,621	2,764,245	4,676,866	0.297760	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,127,325	480,546	1,607,871	1.185350	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,526,353	2,322,547	5,848,900	0.018658	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,894,083	54,451,650	75,345,733	0.088113	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,506,885	10,884,677	21,391,562	0.132340	0.000000	59.00
60.00	06000	LABORATORY	30,565,750	29,975,206	60,540,956	0.117637	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,583,489	148,597	3,732,086	0.202532	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	12,898,893	1,373,703	14,272,596	0.123822	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,032,867	3,144,968	5,177,835	0.287693	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,916,473	321,263	3,237,736	0.214554	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	486,016	254,538	740,554	0.268479	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	600,000	2,611,701	3,211,701	0.073572	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,849,911	9,127,677	15,977,588	0.337470	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,578,104	17,329,531	36,907,635	0.102166	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,929,703	13,674,688	69,604,391	0.117209	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,369,910	25,690	2,395,600	0.216351	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,664,187	3,025,779	5,689,966	0.149277	0.000000	76.02
76.03	03952	WOUND CARE	1,817,476	5,069,636	6,887,112	0.307400	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,604	89,143	93,747	4.229618	0.000000	90.00
91.00	09100	EMERGENCY	8,363,492	38,618,860	46,982,352	0.125158	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	744,948	4,528,599	5,273,547	0.245503	0.000000	92.00
200.00		Subtotal (see instructions)	284,045,307	222,614,571	506,659,878			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	284,045,307	222,614,571	506,659,878			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet C Part I Date/Time Prepared: 10/30/2015 5:01 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT			31.01
33.00	03300 BURN INTENSIVE CARE UNIT			33.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.118097		50.00
50.01	03330 ENDOSCOPY	0.168242		50.01
51.00	05100 RECOVERY ROOM	0.297760		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.185350		52.00
53.00	05300 ANESTHESIOLOGY	0.018658		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.088113		54.00
54.01	03630 ULTRA SOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.132340		59.00
60.00	06000 LABORATORY	0.117637		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.202532		62.00
65.00	06500 RESPIRATORY THERAPY	0.123822		65.00
66.00	06600 PHYSICAL THERAPY	0.287693		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.214554		67.00
68.00	06800 SPEECH PATHOLOGY	0.268479		68.00
69.00	06900 ELECTROCARDIOLOGY	0.073572		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.337470		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.102166		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.117209		73.00
74.00	07400 RENAL DIALYSIS	0.216351		74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000		76.00
76.01	03951 SLEEP LAB	0.000000		76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.149277		76.02
76.03	03952 WOUND CARE	0.307400		76.03
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	4.229618		90.00
91.00	09100 EMERGENCY	0.125158		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.245503		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 150047

Period: From 06/01/2014 To 05/31/2015

Worksheet C Part II Date/Time Prepared: 10/30/2015 5:01 pm

Cost Center Description			Title XIX			Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,755,481	761,312	3,994,169	0	0	50.00
50.01	03330	ENDOSCOPY	732,399	102,306	630,093	0	0	50.01
51.00	05100	RECOVERY ROOM	1,392,584	291,527	1,101,057	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,905,890	262,156	1,643,734	0	0	52.00
53.00	05300	ANESTHESIOLOGY	109,127	10,792	98,335	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,638,930	859,579	5,779,351	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,830,963	151,708	2,679,255	0	0	59.00
60.00	06000	LABORATORY	7,121,865	766,000	6,355,865	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	755,865	41,989	713,876	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,767,258	275,681	1,491,577	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,489,629	326,810	1,162,819	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	694,668	127,844	566,824	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	198,823	47,991	150,832	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	236,290	51,287	185,003	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,391,953	171,911	5,220,042	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,770,709	155,749	3,614,960	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,158,266	261,004	7,897,262	0	0	73.00
74.00	07400	RENAL DIALYSIS	518,291	90,737	427,554	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	849,382	149,982	699,400	0	0	76.02
76.03	03952	WOUND CARE	2,117,101	390,914	1,726,187	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	396,514	91,005	305,509	0	0	90.00
91.00	09100	EMERGENCY	5,880,217	722,160	5,158,057	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,294,672	190,468	1,104,204	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	59,006,877	6,300,912	52,705,965	0	0	200.00
201.00		Less Observation Beds	1,294,672	190,468	1,104,204	0	0	201.00
202.00		Total (line 200 minus line 201)	57,712,205	6,110,444	51,601,761	0	0	202.00

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

Provider CCN: 150047

Period: From 06/01/2014 To 05/31/2015

Worksheet C Part II Date/Time Prepared: 10/30/2015 5:01 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	4,755,481	40,267,709	0.118097	50.00
50.01	03330 ENDOSCOPY	732,399	4,353,242	0.168242	50.01
51.00	05100 RECOVERY ROOM	1,392,584	4,676,866	0.297760	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,905,890	1,607,871	1.185350	52.00
53.00	05300 ANESTHESIOLOGY	109,127	5,848,900	0.018658	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,638,930	75,345,733	0.088113	54.00
54.01	03630 ULTRA SOUND	0	0	0.000000	54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700 CT SCAN	0	0	0.000000	57.00
58.00	05800 MRI	0	0	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	2,830,963	21,391,562	0.132340	59.00
60.00	06000 LABORATORY	7,121,865	60,540,956	0.117637	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	755,865	3,732,086	0.202532	62.00
65.00	06500 RESPIRATORY THERAPY	1,767,258	14,272,596	0.123822	65.00
66.00	06600 PHYSICAL THERAPY	1,489,629	5,177,835	0.287693	66.00
67.00	06700 OCCUPATIONAL THERAPY	694,668	3,237,736	0.214554	67.00
68.00	06800 SPEECH PATHOLOGY	198,823	740,554	0.268479	68.00
69.00	06900 ELECTROCARDIOLOGY	236,290	3,211,701	0.073572	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,391,953	15,977,588	0.337470	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,770,709	36,907,635	0.102166	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,158,266	69,604,391	0.117209	73.00
74.00	07400 RENAL DIALYSIS	518,291	2,395,600	0.216351	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	76.00
76.01	03951 SLEEP LAB	0	0	0.000000	76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	849,382	5,689,966	0.149277	76.02
76.03	03952 WOUND CARE	2,117,101	6,887,112	0.307400	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	396,514	93,747	4.229618	90.00
91.00	09100 EMERGENCY	5,880,217	46,982,352	0.125158	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,294,672	5,273,547	0.245503	92.00
200.00	Subtotal (sum of lines 50 thru 199)	59,006,877	434,217,285		200.00
201.00	Less Observation Beds	1,294,672	0		201.00
202.00	Total (line 200 minus line 201)	57,712,205	434,217,285		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part I Date/Time Prepared: 10/30/2015 5:01 pm
		Title XVIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,123,823	0	2,123,823	28,021	75.79	30.00	
31.00	INTENSIVE CARE UNIT	558,726		558,726	1,167	478.77	31.00	
31.01	NEONATAL INTENSIVE CARE UNIT	0		0	0	0.00	31.01	
33.00	BURN INTENSIVE CARE UNIT	342,392		342,392	1,072	319.40	33.00	
40.00	SUBPROVIDER - IPF	386,421	0	386,421	8,539	45.25	40.00	
43.00	NURSERY	140,509		140,509	1,853	75.83	43.00	
44.00	SKILLED NURSING FACILITY	491,238		491,238	4,847	101.35	44.00	
200.00	Total (Lines 30-199)	4,043,109		4,043,109	45,499		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	5,369	406,917					30.00
31.00	INTENSIVE CARE UNIT	423	202,520					31.00
31.01	NEONATAL INTENSIVE CARE UNIT	0	0					31.01
33.00	BURN INTENSIVE CARE UNIT	162	51,743					33.00
40.00	SUBPROVIDER - IPF	4,052	183,353					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	1,902	192,768					44.00
200.00	Total (Lines 30-199)	11,908	1,037,301					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part II Date/Time Prepared: 10/30/2015 5:01 pm
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Cost Center Description		Title XVIII			Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	761,312	40,267,709	0.018906	5,636,162	106,557	50.00
50.01	03330	ENDOSCOPY	102,306	4,353,242	0.023501	388,223	9,124	50.01
51.00	05100	RECOVERY ROOM	291,527	4,676,866	0.062334	449,670	28,030	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	262,156	1,607,871	0.163045	5,326	868	52.00
53.00	05300	ANESTHESIOLOGY	10,792	5,848,900	0.001845	782,299	1,443	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	859,579	75,345,733	0.011408	6,950,192	79,288	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	151,708	21,391,562	0.007092	3,308,685	23,465	59.00
60.00	06000	LABORATORY	766,000	60,540,956	0.012653	7,637,466	96,637	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	41,989	3,732,086	0.011251	1,098,632	12,361	62.00
65.00	06500	RESPIRATORY THERAPY	275,681	14,272,596	0.019315	3,883,474	75,009	65.00
66.00	06600	PHYSICAL THERAPY	326,810	5,177,835	0.063117	408,602	25,790	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,844	3,237,736	0.039486	318,369	12,571	67.00
68.00	06800	SPEECH PATHOLOGY	47,991	740,554	0.064804	60,088	3,894	68.00
69.00	06900	ELECTROCARDIOLOGY	51,287	3,211,701	0.015969	400,382	6,394	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	171,911	15,977,588	0.010760	2,605,686	28,037	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155,749	36,907,635	0.004220	6,755,730	28,509	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	261,004	69,604,391	0.003750	12,973,200	48,650	73.00
74.00	07400	RENAL DIALYSIS	90,737	2,395,600	0.037877	796,036	30,151	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	149,982	5,689,966	0.026359	501,948	13,231	76.02
76.03	03952	WOUND CARE	390,914	6,887,112	0.056760	353,892	20,087	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	91,005	93,747	0.970751	131	127	90.00
91.00	09100	EMERGENCY	722,160	46,982,352	0.015371	2,161,646	33,227	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	190,468	5,273,547	0.036118	213,929	7,727	92.00
200.00		Total (lines 50-199)	6,300,912	434,217,285		57,689,768	691,177	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150047		Period: From 06/01/2014 To 05/31/2015		Worksheet D Part III Date/Time Prepared: 10/30/2015 5:01 pm	
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
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
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	28,021	0.00	5,369	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,167	0.00	423	0		31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0.00	0	0		31.01
33.00	03300	BURN INTENSIVE CARE UNIT	1,072	0.00	162	0		33.00
40.00	04000	SUBPROVIDER - IPF	8,539	0.00	4,052	0		40.00
43.00	04300	NURSERY	1,853	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	4,847	0.00	1,902	0		44.00
200.00		Total (lines 30-199)	45,499		11,908	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet D
Part IV
Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description		Title XVIII				Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
50.01	03330	ENDOSCOPY	0	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part IV Date/Time Prepared: 10/30/2015 5:01 pm
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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	
			6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	40,267,709	0.000000	0.000000	5,636,162	50.00
50.01	03330	ENDOSCOPY	0	4,353,242	0.000000	0.000000	388,223	50.01
51.00	05100	RECOVERY ROOM	0	4,676,866	0.000000	0.000000	449,670	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,607,871	0.000000	0.000000	5,326	52.00
53.00	05300	ANESTHESIOLOGY	0	5,848,900	0.000000	0.000000	782,299	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	75,345,733	0.000000	0.000000	6,950,192	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	21,391,562	0.000000	0.000000	3,308,685	59.00
60.00	06000	LABORATORY	0	60,540,956	0.000000	0.000000	7,637,466	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,732,086	0.000000	0.000000	1,098,632	62.00
65.00	06500	RESPIRATORY THERAPY	0	14,272,596	0.000000	0.000000	3,883,474	65.00
66.00	06600	PHYSICAL THERAPY	0	5,177,835	0.000000	0.000000	408,602	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,237,736	0.000000	0.000000	318,369	67.00
68.00	06800	SPEECH PATHOLOGY	0	740,554	0.000000	0.000000	60,088	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,211,701	0.000000	0.000000	400,382	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,977,588	0.000000	0.000000	2,605,686	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	36,907,635	0.000000	0.000000	6,755,730	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	69,604,391	0.000000	0.000000	12,973,200	73.00
74.00	07400	RENAL DIALYSIS	0	2,395,600	0.000000	0.000000	796,036	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	5,689,966	0.000000	0.000000	501,948	76.02
76.03	03952	WOUND CARE	0	6,887,112	0.000000	0.000000	353,892	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	93,747	0.000000	0.000000	131	90.00
91.00	09100	EMERGENCY	0	46,982,352	0.000000	0.000000	2,161,646	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,273,547	0.000000	0.000000	213,929	92.00
200.00		Total (lines 50-199)	0	434,217,285			57,689,768	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part IV Date/Time Prepared: 10/30/2015 5:01 pm
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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)	Hospital	PPS
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00		
50.00	05000 OPERATING ROOM	0	4,801,927	0		50.00
50.01	03330 ENDOSCOPY	0	921,043	0		50.01
51.00	05100 RECOVERY ROOM	0	1,501,099	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3,302	0		52.00
53.00	05300 ANESTHESIOLOGY	0	545,583	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	10,030,173	0		54.00
54.01	03630 ULTRA SOUND	0	0	0		54.01
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MRI	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	3,396,338	0		59.00
60.00	06000 LABORATORY	0	2,777,369	0		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	58,733	0		62.00
65.00	06500 RESPIRATORY THERAPY	0	353,481	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	324	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	425,493	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,145,167	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	7,911,722	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,058,516	0		73.00
74.00	07400 RENAL DIALYSIS	0	16,030	0		74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0		76.00
76.01	03951 SLEEP LAB	0	0	0		76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,178,635	0		76.02
76.03	03952 WOUND CARE	0	1,379,597	0		76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	10,676	0		90.00
91.00	09100 EMERGENCY	0	4,492,538	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	636,725	0		92.00
200.00	Total (lines 50-199)	0	45,644,471	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part V Date/Time Prepared: 10/30/2015 5:01 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.118097	4,801,927	0	0	567,093 50.00
50.01 03330 ENDOSCOPY	0.168242	921,043	0	0	154,958 50.01
51.00 05100 RECOVERY ROOM	0.297760	1,501,099	0	0	446,967 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.185350	3,302	0	0	3,914 52.00
53.00 05300 ANESTHESIOLOGY	0.018658	545,583	0	0	10,179 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.088113	10,030,173	0	0	883,789 54.00
54.01 03630 ULTRA SOUND	0.000000	0	0	0	0 54.01
56.00 05600 RADIO SOTOP	0.000000	0	0	0	0 56.00
57.00 05700 CT SCAN	0.000000	0	0	0	0 57.00
58.00 05800 MRI	0.000000	0	0	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.132340	3,396,338	0	0	449,471 59.00
60.00 06000 LABORATORY	0.117637	2,777,369	0	0	326,721 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.202532	58,733	0	0	11,895 62.00
65.00 06500 RESPIRATORY THERAPY	0.123822	353,481	0	0	43,769 65.00
66.00 06600 PHYSICAL THERAPY	0.287693	0	0	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.214554	324	0	0	70 67.00
68.00 06800 SPEECH PATHOLOGY	0.268479	0	0	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0.073572	425,493	0	0	31,304 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.337470	2,145,167	0	0	723,930 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.102166	7,911,722	0	0	808,309 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.117209	3,058,516	0	20,781	358,486 73.00
74.00 07400 RENAL DIALYSIS	0.216351	16,030	0	0	3,468 74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0 76.00
76.01 03951 SLEEP LAB	0.000000	0	0	0	0 76.01
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.149277	1,178,635	0	0	175,943 76.02
76.03 03952 WOUND CARE	0.307400	1,379,597	0	0	424,088 76.03
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	4.229618	10,676	0	0	45,155 90.00
91.00 09100 EMERGENCY	0.125158	4,492,538	0	0	562,277 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.245503	636,725	0	0	156,318 92.00
200.00	Subtotal (see instructions)	45,644,471	0	20,781	6,188,104 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	45,644,471	0	20,781	6,188,104 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part V Date/Time Prepared: 10/30/2015 5:01 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
50.01 03330 ENDOSCOPY	0	0		50.01
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 03630 ULTRA SOUND	0	0		54.01
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,436		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.01 03951 SLEEP LAB	0	0		76.01
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03 03952 WOUND CARE	0	0		76.03
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
200.00 Subtotal (see instructions)	0	2,436		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	2,436		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150047 Component CCN: 15S047		Period: From 06/01/2014 To 05/31/2015		Worksheet D Part II Date/Time Prepared: 10/30/2015 5:01 pm		
		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	761,312	40,267,709	0.018906	21,456	406	50.00
50.01	03330	ENDOSCOPY	102,306	4,353,242	0.023501	27,340	643	50.01
51.00	05100	RECOVERY ROOM	291,527	4,676,866	0.062334	265,116	16,526	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	262,156	1,607,871	0.163045	0	0	52.00
53.00	05300	ANESTHESIOLOGY	10,792	5,848,900	0.001845	72,738	134	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	859,579	75,345,733	0.011408	563,243	6,425	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	151,708	21,391,562	0.007092	0	0	59.00
60.00	06000	LABORATORY	766,000	60,540,956	0.012653	1,205,991	15,259	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	41,989	3,732,086	0.011251	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	275,681	14,272,596	0.019315	239,230	4,621	65.00
66.00	06600	PHYSICAL THERAPY	326,810	5,177,835	0.063117	106,648	6,731	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,844	3,237,736	0.039486	85,162	3,363	67.00
68.00	06800	SPEECH PATHOLOGY	47,991	740,554	0.064804	18,948	1,228	68.00
69.00	06900	ELECTROCARDIOLOGY	51,287	3,211,701	0.015969	77,601	1,239	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	171,911	15,977,588	0.010760	52,349	563	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155,749	36,907,635	0.004220	59,237	250	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	261,004	69,604,391	0.003750	2,085,508	7,821	73.00
74.00	07400	RENAL DIALYSIS	90,737	2,395,600	0.037877	10,892	413	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	149,982	5,689,966	0.026359	271,257	7,150	76.02
76.03	03952	WOUND CARE	390,914	6,887,112	0.056760	8,420	478	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	91,005	93,747	0.970751	131	127	90.00
91.00	09100	EMERGENCY	722,160	46,982,352	0.015371	286,588	4,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,273,547	0.000000	0	0	92.00
200.00		Total (lines 50-199)	6,110,444	434,217,285		5,457,855	77,782	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150047
Component CCN: 15S047

Period:
From 06/01/2014
To 05/31/2015

Worksheet D
Part IV
Date/Time Prepared:
10/30/2015 5:01 pm

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	50.00
50.01	03330	ENDOSCOPY	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	76.03
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
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150047 Component CCN: 15S047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part IV Date/Time Prepared: 10/30/2015 5:01 pm PPS
		Title XVIII	Subprovider - IPF

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	40,267,709	0.000000	0.000000	21,456 50.00
50.01 03330 ENDOSCOPY	0	4,353,242	0.000000	0.000000	27,340 50.01
51.00 05100 RECOVERY ROOM	0	4,676,866	0.000000	0.000000	265,116 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1,607,871	0.000000	0.000000	0 52.00
53.00 05300 ANESTHESIOLOGY	0	5,848,900	0.000000	0.000000	72,738 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	75,345,733	0.000000	0.000000	563,243 54.00
54.01 03630 ULTRA SOUND	0	0	0.000000	0.000000	0 54.01
56.00 05600 RADIOISOTOPE	0	0	0.000000	0.000000	0 56.00
57.00 05700 CT SCAN	0	0	0.000000	0.000000	0 57.00
58.00 05800 MRI	0	0	0.000000	0.000000	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	21,391,562	0.000000	0.000000	0 59.00
60.00 06000 LABORATORY	0	60,540,956	0.000000	0.000000	1,205,991 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,732,086	0.000000	0.000000	0 62.00
65.00 06500 RESPIRATORY THERAPY	0	14,272,596	0.000000	0.000000	239,230 65.00
66.00 06600 PHYSICAL THERAPY	0	5,177,835	0.000000	0.000000	106,648 66.00
67.00 06700 OCCUPATIONAL THERAPY	0	3,237,736	0.000000	0.000000	85,162 67.00
68.00 06800 SPEECH PATHOLOGY	0	740,554	0.000000	0.000000	18,948 68.00
69.00 06900 ELECTROCARDIOLOGY	0	3,211,701	0.000000	0.000000	77,601 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,977,588	0.000000	0.000000	52,349 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	36,907,635	0.000000	0.000000	59,237 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	69,604,391	0.000000	0.000000	2,085,508 73.00
74.00 07400 RENAL DIALYSIS	0	2,395,600	0.000000	0.000000	10,892 74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0 76.00
76.01 03951 SLEEP LAB	0	0	0.000000	0.000000	0 76.01
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	5,689,966	0.000000	0.000000	271,257 76.02
76.03 03952 WOUND CARE	0	6,887,112	0.000000	0.000000	8,420 76.03
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	93,747	0.000000	0.000000	131 90.00
91.00 09100 EMERGENCY	0	46,982,352	0.000000	0.000000	286,588 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5,273,547	0.000000	0.000000	0 92.00
200.00 Total (lines 50-199)	0	434,217,285			5,457,855 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part IV Date/Time Prepared: 10/30/2015 5:01 pm
	Component CCN: 15S047	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	0	0	50.00
50.01	03330 ENDOSCOPY	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	03630 ULTRA SOUND	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO 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
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	76.00
76.01	03951 SLEEP LAB	0	0	0	76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	76.02
76.03	03952 WOUND CARE	0	0	0	76.03
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
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150047

Period:

Worksheet D

Component CCN: 155356

From 06/01/2014
To 05/31/2015

Part IV
Date/Time Prepared:
10/30/2015 5:01 pm

Title XVIII

Skilled Nursing Facility

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	50.00
50.01	03330	ENDOSCOPY	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	76.03
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
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150047 Component CCN: 155356	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part IV Date/Time Prepared: 10/30/2015 5:01 pm PPS
		Title XVIII	Skilled Nursing Facility

Cost Center Description	Total	Total	Ratio of Cost	Outpatient	Inpatient Program Charges	
	Outpatient Cost (sum of col. 2, 3 and 4)	Charges (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	40,267,709	0.000000	0.000000	1,070	50.00
50.01 03330 ENDOSCOPY	0	4,353,242	0.000000	0.000000	0	50.01
51.00 05100 RECOVERY ROOM	0	4,676,866	0.000000	0.000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1,607,871	0.000000	0.000000	0	52.00
53.00 05300 ANESTHESIOLOGY	0	5,848,900	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	75,345,733	0.000000	0.000000	108,810	54.00
54.01 03630 ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
56.00 05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00 05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00 05800 MRI	0	0	0.000000	0.000000	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	21,391,562	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	60,540,956	0.000000	0.000000	405,365	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,732,086	0.000000	0.000000	3,395	62.00
65.00 06500 RESPIRATORY THERAPY	0	14,272,596	0.000000	0.000000	289,223	65.00
66.00 06600 PHYSICAL THERAPY	0	5,177,835	0.000000	0.000000	663,996	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	3,237,736	0.000000	0.000000	679,789	67.00
68.00 06800 SPEECH PATHOLOGY	0	740,554	0.000000	0.000000	30,448	68.00
69.00 06900 ELECTROCARDIOLOGY	0	3,211,701	0.000000	0.000000	7,177	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,977,588	0.000000	0.000000	127,227	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	36,907,635	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	69,604,391	0.000000	0.000000	1,570,445	73.00
74.00 07400 RENAL DIALYSIS	0	2,395,600	0.000000	0.000000	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.01 03951 SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	5,689,966	0.000000	0.000000	0	76.02
76.03 03952 WOUND CARE	0	6,887,112	0.000000	0.000000	71,371	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	93,747	0.000000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	46,982,352	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5,273,547	0.000000	0.000000	3,277	92.00
200.00 Total (lines 50-199)	0	434,217,285			3,961,593	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part IV Date/Time Prepared: 10/30/2015 5:01 pm
	Component CCN: 155356	Title XVIII	Skilled Nursing Facility PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
50.01	03330 ENDOSCOPY	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	03630 ULTRA SOUND	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO 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
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	76.00
76.01	03951 SLEEP LAB	0	0	0	76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	76.02
76.03	03952 WOUND CARE	0	0	0	76.03
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
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part I Date/Time Prepared: 10/30/2015 5:01 pm
		Title XIX	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,123,823	0	2,123,823	28,021	75.79	30.00	
31.00	INTENSIVE CARE UNIT	558,726		558,726	1,167	478.77	31.00	
31.01	NEONATAL INTENSIVE CARE UNIT	0		0	0	0.00	31.01	
33.00	BURN INTENSIVE CARE UNIT	342,392		342,392	1,072	319.40	33.00	
40.00	SUBPROVIDER - IPF	386,421	0	386,421	8,539	45.25	40.00	
43.00	NURSERY	140,509		140,509	1,853	75.83	43.00	
44.00	SKILLED NURSING FACILITY	491,238		491,238	4,847	101.35	44.00	
200.00	Total (Lines 30-199)	4,043,109		4,043,109	45,499		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	1,963	148,776					30.00
31.00	INTENSIVE CARE UNIT	81	38,780					31.00
31.01	NEONATAL INTENSIVE CARE UNIT	0	0					31.01
33.00	BURN INTENSIVE CARE UNIT	207	66,116					33.00
40.00	SUBPROVIDER - IPF	532	24,073					40.00
43.00	NURSERY	811	61,498					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (Lines 30-199)	3,594	339,243					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part II Date/Time Prepared: 10/30/2015 5:01 pm
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Cost Center Description		Title XIX			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	761,312	40,267,709	0.018906	2,049,091	38,740	50.00
50.01	03330	ENDOSCOPY	102,306	4,353,242	0.023501	100,629	2,365	50.01
51.00	05100	RECOVERY ROOM	291,527	4,676,866	0.062334	237,681	14,816	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	262,156	1,607,871	0.163045	439,220	71,613	52.00
53.00	05300	ANESTHESIOLOGY	10,792	5,848,900	0.001845	395,556	730	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	859,579	75,345,733	0.011408	2,336,800	26,658	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	151,708	21,391,562	0.007092	665,166	4,717	59.00
60.00	06000	LABORATORY	766,000	60,540,956	0.012653	3,634,731	45,990	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	41,989	3,732,086	0.011251	439,750	4,948	62.00
65.00	06500	RESPIRATORY THERAPY	275,681	14,272,596	0.019315	1,303,168	25,171	65.00
66.00	06600	PHYSICAL THERAPY	326,810	5,177,835	0.063117	153,572	9,693	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,844	3,237,736	0.039486	131,910	5,209	67.00
68.00	06800	SPEECH PATHOLOGY	47,991	740,554	0.064804	110,965	7,191	68.00
69.00	06900	ELECTROCARDIOLOGY	51,287	3,211,701	0.015969	112,020	1,789	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	171,911	15,977,588	0.010760	994,484	10,701	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155,749	36,907,635	0.004220	1,208,255	5,099	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	261,004	69,604,391	0.003750	6,271,132	23,517	73.00
74.00	07400	RENAL DIALYSIS	90,737	2,395,600	0.037877	157,288	5,958	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	149,982	5,689,966	0.026359	304,655	8,030	76.02
76.03	03952	WOUND CARE	390,914	6,887,112	0.056760	164,020	9,310	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	91,005	93,747	0.970751	240	233	90.00
91.00	09100	EMERGENCY	722,160	46,982,352	0.015371	978,917	15,047	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	190,468	5,273,547	0.036118	81,188	2,932	92.00
200.00		Total (lines 50-199)	6,300,912	434,217,285		22,270,438	340,457	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part III Date/Time Prepared: 10/30/2015 5:01 pm
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Cost Center Description			Title XIX			Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	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	28,021	0.00	1,963	0			30.00
31.00	03100	INTENSIVE CARE UNIT	1,167	0.00	81	0			31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0.00	0	0			31.01
33.00	03300	BURN INTENSIVE CARE UNIT	1,072	0.00	207	0			33.00
40.00	04000	SUBPROVIDER - IPF	8,539	0.00	532	0			40.00
43.00	04300	NURSERY	1,853	0.00	811	0			43.00
44.00	04400	SKILLED NURSING FACILITY	4,847	0.00	0	0			44.00
200.00		Total (lines 30-199)	45,499		3,594	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet D
Part IV
Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description		Title XIX				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
50.01	03330	ENDOSCOPY	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	76.03
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
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet D
Part IV
Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description			Title XIX			Hospital		PPS
			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	40,267,709	0.000000	0.000000	2,049,091	50.00
50.01	03330	ENDOSCOPY	0	4,353,242	0.000000	0.000000	100,629	50.01
51.00	05100	RECOVERY ROOM	0	4,676,866	0.000000	0.000000	237,681	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,607,871	0.000000	0.000000	439,220	52.00
53.00	05300	ANESTHESIOLOGY	0	5,848,900	0.000000	0.000000	395,556	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	75,345,733	0.000000	0.000000	2,336,800	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	21,391,562	0.000000	0.000000	665,166	59.00
60.00	06000	LABORATORY	0	60,540,956	0.000000	0.000000	3,634,731	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,732,086	0.000000	0.000000	439,750	62.00
65.00	06500	RESPIRATORY THERAPY	0	14,272,596	0.000000	0.000000	1,303,168	65.00
66.00	06600	PHYSICAL THERAPY	0	5,177,835	0.000000	0.000000	153,572	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,237,736	0.000000	0.000000	131,910	67.00
68.00	06800	SPEECH PATHOLOGY	0	740,554	0.000000	0.000000	110,965	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,211,701	0.000000	0.000000	112,020	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,977,588	0.000000	0.000000	994,484	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	36,907,635	0.000000	0.000000	1,208,255	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	69,604,391	0.000000	0.000000	6,271,132	73.00
74.00	07400	RENAL DIALYSIS	0	2,395,600	0.000000	0.000000	157,288	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	5,689,966	0.000000	0.000000	304,655	76.02
76.03	03952	WOUND CARE	0	6,887,112	0.000000	0.000000	164,020	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	93,747	0.000000	0.000000	240	90.00
91.00	09100	EMERGENCY	0	46,982,352	0.000000	0.000000	978,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,273,547	0.000000	0.000000	81,188	92.00
200.00		Total (lines 50-199)	0	434,217,285			22,270,438	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet D
Part IV
Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description		Title XIX			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
50.01	03330 ENDOSCOPY	0	0	0		50.01
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	03630 ULTRA SOUND	0	0	0		54.01
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MRI	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO 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
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0		76.00
76.01	03951 SLEEP LAB	0	0	0		76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03952 WOUND CARE	0	0	0		76.03
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
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part V Date/Time Prepared: 10/30/2015 5:01 pm
		Title XIX	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	0.118097	0	0	1,506,328	0
50.01 03330 ENDOSCOPY	0.168242	0	0	174,268	0
51.00 05100 RECOVERY ROOM	0.297760	0	0	298,824	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.185350	0	0	115,380	0
53.00 05300 ANESTHESIOLOGY	0.018658	0	0	258,765	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.088113	0	0	4,861,328	0
54.01 03630 ULTRA SOUND	0.000000	0	0	0	0
56.00 05600 RADIO SOTOP	0.000000	0	0	0	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MRI	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.132340	0	0	467,086	0
60.00 06000 LABORATORY	0.117637	0	0	3,011,619	0
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.202532	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.123822	0	0	171,400	0
66.00 06600 PHYSICAL THERAPY	0.287693	0	0	127,860	0
67.00 06700 OCCUPATIONAL THERAPY	0.214554	0	0	15,924	0
68.00 06800 SPEECH PATHOLOGY	0.268479	0	0	7,747	0
69.00 06900 ELECTROCARDIOLOGY	0.073572	0	0	183,799	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.337470	0	0	421,456	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.102166	0	0	1,046,096	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.117209	0	0	1,244,142	0
74.00 07400 RENAL DIALYSIS	0.216351	0	0	0	0
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0
76.01 03951 SLEEP LAB	0.000000	0	0	0	0
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.149277	0	0	87,974	0
76.03 03952 WOUND CARE	0.307400	0	0	268,290	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	4.229618	0	0	7,130	0
91.00 09100 EMERGENCY	0.125158	0	0	5,175,398	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.245503	0	0	284,647	0
200.00 Subtotal (see instructions)		0	0	19,735,461	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	19,735,461	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part V Date/Time Prepared: 10/30/2015 5:01 pm
		Title XIX	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	177,893	50.00
50.01	03330	ENDOSCOPY	0	29,319	50.01
51.00	05100	RECOVERY ROOM	0	88,978	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	136,766	52.00
53.00	05300	ANESTHESIOLOGY	0	4,828	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	428,346	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	61,814	59.00
60.00	06000	LABORATORY	0	354,278	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	21,223	65.00
66.00	06600	PHYSICAL THERAPY	0	36,784	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,417	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,080	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,522	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	142,229	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	106,875	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	145,825	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.01	03951	SLEEP LAB	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	13,132	76.02
76.03	03952	WOUND CARE	0	82,472	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	30,157	90.00
91.00	09100	EMERGENCY	0	647,742	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	69,882	92.00
200.00		Subtotal (see instructions)	0	2,597,562	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	2,597,562	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part II Date/Time Prepared: 10/30/2015 5:01 pm
		Component CCN: 15S047	Title XIX	Subprovider - IPF

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	761,312	40,267,709	0.018906	0	0	50.00
50.01	03330	ENDOSCOPY	102,306	4,353,242	0.023501	0	0	50.01
51.00	05100	RECOVERY ROOM	291,527	4,676,866	0.062334	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	262,156	1,607,871	0.163045	0	0	52.00
53.00	05300	ANESTHESIOLOGY	10,792	5,848,900	0.001845	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	859,579	75,345,733	0.011408	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	151,708	21,391,562	0.007092	0	0	59.00
60.00	06000	LABORATORY	766,000	60,540,956	0.012653	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	41,989	3,732,086	0.011251	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	275,681	14,272,596	0.019315	0	0	65.00
66.00	06600	PHYSICAL THERAPY	326,810	5,177,835	0.063117	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,844	3,237,736	0.039486	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	47,991	740,554	0.064804	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	51,287	3,211,701	0.015969	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	171,911	15,977,588	0.010760	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155,749	36,907,635	0.004220	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	261,004	69,604,391	0.003750	0	0	73.00
74.00	07400	RENAL DIALYSIS	90,737	2,395,600	0.037877	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	149,982	5,689,966	0.026359	0	0	76.02
76.03	03952	WOUND CARE	390,914	6,887,112	0.056760	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	91,005	93,747	0.970751	0	0	90.00
91.00	09100	EMERGENCY	722,160	46,982,352	0.015371	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,273,547	0.000000	0	0	92.00
200.00		Total (lines 50-199)	6,110,444	434,217,285		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150047 Component CCN: 15S047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part IV Date/Time Prepared: 10/30/2015 5:01 pm
Title XIX		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	50.00
50.01	03330	ENDOSCOPY	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	76.03
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
200.00		Total (Lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150047 Component CCN: 15S047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part IV Date/Time Prepared: 10/30/2015 5:01 pm PPS
		Title XIX	Subprovider - IPF

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	40,267,709	0.000000	0.000000		0 50.00
50.01	03330 ENDOSCOPY	0	4,353,242	0.000000	0.000000		0 50.01
51.00	05100 RECOVERY ROOM	0	4,676,866	0.000000	0.000000		0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,607,871	0.000000	0.000000		0 52.00
53.00	05300 ANESTHESIOLOGY	0	5,848,900	0.000000	0.000000		0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	75,345,733	0.000000	0.000000		0 54.00
54.01	03630 ULTRA SOUND	0	0	0.000000	0.000000		0 54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	0.000000		0 56.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000		0 57.00
58.00	05800 MRI	0	0	0.000000	0.000000		0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0	21,391,562	0.000000	0.000000		0 59.00
60.00	06000 LABORATORY	0	60,540,956	0.000000	0.000000		0 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,732,086	0.000000	0.000000		0 62.00
65.00	06500 RESPIRATORY THERAPY	0	14,272,596	0.000000	0.000000		0 65.00
66.00	06600 PHYSICAL THERAPY	0	5,177,835	0.000000	0.000000		0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0	3,237,736	0.000000	0.000000		0 67.00
68.00	06800 SPEECH PATHOLOGY	0	740,554	0.000000	0.000000		0 68.00
69.00	06900 ELECTROCARDIOLOGY	0	3,211,701	0.000000	0.000000		0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,977,588	0.000000	0.000000		0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	36,907,635	0.000000	0.000000		0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	69,604,391	0.000000	0.000000		0 73.00
74.00	07400 RENAL DIALYSIS	0	2,395,600	0.000000	0.000000		0 74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000		0 76.00
76.01	03951 SLEEP LAB	0	0	0.000000	0.000000		0 76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	5,689,966	0.000000	0.000000		0 76.02
76.03	03952 WOUND CARE	0	6,887,112	0.000000	0.000000		0 76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	93,747	0.000000	0.000000		0 90.00
91.00	09100 EMERGENCY	0	46,982,352	0.000000	0.000000		0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5,273,547	0.000000	0.000000		0 92.00
200.00	Total (lines 50-199)	0	434,217,285				0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150047 Component CCN: 15S047	Period: From 06/01/2014 To 05/31/2015	Worksheet D Part IV Date/Time Prepared: 10/30/2015 5:01 pm
Title XIX		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	0	0	50.00
50.01	03330 ENDOSCOPY	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	03630 ULTRA SOUND	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO 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
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	76.00
76.01	03951 SLEEP LAB	0	0	0	76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	76.02
76.03	03952 WOUND CARE	0	0	0	76.03
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
200.00	Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D-1 Date/Time Prepared: 10/30/2015 5:01 pm
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)		28,021	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		28,021	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)		25,508	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)		5,369	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)		14,436,251	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)		14,436,251	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)		14,436,251	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)		515.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,766,055	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,766,055	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150047		Period: From 06/01/2014 To 05/31/2015		Worksheet D-1	
		Title XVIII		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	2,619,609	1,167	2,244.74	423	949,525	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	2,404,177	1,072	2,242.70	162	363,317	45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					7,538,952	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,617,849	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)					661,180	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					691,177	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,352,357	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,265,492	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,513	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					515.19	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,294,672	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150047		Period: From 06/01/2014 To 05/31/2015		Worksheet D-1 Date/Time Prepared: 10/30/2015 5:01 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,123,823	14,436,251	0.147117	1,294,672	190,468	90.00
91.00	Nursing School cost	0	14,436,251	0.000000	1,294,672	0	91.00
92.00	Allied health cost	0	14,436,251	0.000000	1,294,672	0	92.00
93.00	All other Medical Education	0	14,436,251	0.000000	1,294,672	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150047 Component CCN: 15S047	Period: From 06/01/2014 To 05/31/2015	Worksheet D-1 Date/Time Prepared: 10/30/2015 5:01 pm
		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)			8,539 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			8,539 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)			8,539 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)			4,052 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)			3,242,113 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)			3,242,113 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)			3,242,113 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)			379.68 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,538,463 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)			1,538,463 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150047		Period: From 06/01/2014 To 05/31/2015		Worksheet D-1		
		Component CCN: 15S047				Date/Time Prepared: 10/30/2015 5:01 pm		
		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	
43.01	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	43.01	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	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)						718,319	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						2,256,782	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)						183,353	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						77,782	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						261,135	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						1,995,647	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						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: 150047 Component CCN: 15S047		Period: From 06/01/2014 To 05/31/2015		Worksheet D-1 Date/Time Prepared: 10/30/2015 5:01 pm	
		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	386,421	3,242,113	0.119188	0	0	90.00
91.00	Nursing School cost	0	3,242,113	0.000000	0	0	91.00
92.00	Allied health cost	0	3,242,113	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,242,113	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150047 Component CCN: 155356	Period: From 06/01/2014 To 05/31/2015	Worksheet D-1 Date/Time Prepared: 10/30/2015 5:01 pm
		Title XVIII	Skilled Nursing Facility	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)		4,847	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,847	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)		4,847	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)		1,902	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)		2,569,469	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)		2,569,469	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)		2,569,469	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D-1	
		Component CCN: 155356		Date/Time Prepared: 10/30/2015 5:01 pm	
		Title XVIII	Skilled Nursing Facility	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)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
43.01	NEONATAL INTENSIVE CARE UNIT				43.01
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)				48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				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)				50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				54.00
55.00	Target amount per discharge				55.00
56.00	Target amount (line 54 x line 55)				56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				57.00
58.00	Bonus payment (see instructions)				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				59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				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)				61.00
62.00	Relief payment (see instructions)				62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				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)				64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				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)				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)				68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				2,569,469
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				530.12
72.00	Program routine service cost (line 9 x line 71)				1,008,288
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				0
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				1,008,288
75.00	Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0
76.00	Per diem capital -related costs (line 75 ÷ line 2)				0.00
77.00	Program capital -related costs (line 9 x line 76)				0
78.00	Inpatient routine service cost (line 74 minus line 77)				0
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				0
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0
81.00	Inpatient routine service cost per diem limitation				0.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				0
83.00	Reasonable inpatient routine service costs (see instructions)				1,008,288
84.00	Program inpatient ancillary services (see instructions)				689,230
85.00	Utilization review - physician compensation (see instructions)				0
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				1,697,518
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150047 Component CCN: 155356		Period: From 06/01/2014 To 05/31/2015		Worksheet D-1 Date/Time Prepared: 10/30/2015 5:01 pm	
		Title XVIII		Skilled Nursing Facility		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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D-1 Date/Time Prepared: 10/30/2015 5:01 pm
		Title XIX	Hospital	PPS
Cost Center Description		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		28,021	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		28,021	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)		25,508	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)		1,963	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,853	15.00
16.00	Nursery days (title V or XIX only)		811	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)		14,436,251	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)		14,436,251	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)		14,436,251	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)		515.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,011,318	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)		1,011,318	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150047		Period: From 06/01/2014 To 05/31/2015		Worksheet D-1	
Title XIX		Hospital		PPS			
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	1,647,924	1,853	889.33	811	721,247		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	2,619,609	1,167	2,244.74	81	181,824		43.00
43.01 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0		43.01
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT	2,404,177	1,072	2,242.70	207	464,239		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)					3,407,631		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,786,259		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)					315,170		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					340,457		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					655,627		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,130,632		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					2,513		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					515.19		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,294,672		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150047		Period: From 06/01/2014 To 05/31/2015		Worksheet D-1 Date/Time Prepared: 10/30/2015 5:01 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,123,823	14,436,251	0.147117	1,294,672	190,468	90.00
91.00	Nursing School cost	0	14,436,251	0.000000	1,294,672	0	91.00
92.00	Allied health cost	0	14,436,251	0.000000	1,294,672	0	92.00
93.00	All other Medical Education	0	14,436,251	0.000000	1,294,672	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150047 Component CCN: 15S047	Period: From 06/01/2014 To 05/31/2015	Worksheet D-1 Date/Time Prepared: 10/30/2015 5:01 pm
		Title XIX	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)		8,539	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,539	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)		8,539	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)		532	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,853	15.00
16.00	Nursery days (title V or XIX only)		811	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)		3,242,113	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)		3,242,113	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)		3,242,113	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)		379.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		201,990	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)		201,990	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150047		Period: From 06/01/2014 To 05/31/2015		Worksheet D-1		
		Component CCN: 15S047				Date/Time Prepared: 10/30/2015 5:01 pm		
		Title XIX		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	
43.01	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	43.01	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	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)						0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						201,990	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)						24,073	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						24,073	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						177,917	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						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: 150047 Component CCN: 15S047		Period: From 06/01/2014 To 05/31/2015		Worksheet D-1 Date/Time Prepared: 10/30/2015 5:01 pm	
		Title XIX		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	386,421	3,242,113	0.119188	0	0	90.00
91.00	Nursing School cost	0	3,242,113	0.000000	0	0	91.00
92.00	Allied health cost	0	3,242,113	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,242,113	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D-3 Date/Time Prepared: 10/30/2015 5:01 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		12,002,414	30.00
31.00	03100	INTENSIVE CARE UNIT		1,563,082	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT		924,952	33.00
40.00	04000	SUBPROVIDER - I PF		0	40.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.118097	5,636,162	50.00
50.01	03330	ENDOSCOPY	0.168242	388,223	50.01
51.00	05100	RECOVERY ROOM	0.297760	449,670	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.185350	5,326	52.00
53.00	05300	ANESTHESIOLOGY	0.018658	782,299	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088113	6,950,192	54.00
54.01	03630	ULTRA SOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MRI	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.132340	3,308,685	59.00
60.00	06000	LABORATORY	0.117637	7,637,466	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.202532	1,098,632	62.00
65.00	06500	RESPIRATORY THERAPY	0.123822	3,883,474	65.00
66.00	06600	PHYSICAL THERAPY	0.287693	408,602	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.214554	318,369	67.00
68.00	06800	SPEECH PATHOLOGY	0.268479	60,088	68.00
69.00	06900	ELECTROCARDIOLOGY	0.073572	400,382	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.337470	2,605,686	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.102166	6,755,730	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117209	12,973,200	73.00
74.00	07400	RENAL DIALYSIS	0.216351	796,036	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.149277	501,948	76.02
76.03	03952	WOUND CARE	0.307400	353,892	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	4.229618	131	90.00
91.00	09100	EMERGENCY	0.125158	2,161,646	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.245503	213,929	92.00
200.00		Total (sum of lines 50-94 and 96-98)		57,689,768	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)		57,689,768	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D-3	
		Component CCN: 15S047		Date/Time Prepared: 10/30/2015 5:01 pm	
		Title XVIIII	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
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
40.00	04000	SUBPROVIDER - IPF		11,449,606	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.118097	21,456	50.00
50.01	03330	ENDOSCOPY	0.168242	27,340	50.01
51.00	05100	RECOVERY ROOM	0.297760	265,116	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.185350	0	52.00
53.00	05300	ANESTHESIOLOGY	0.018658	72,738	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088113	563,243	54.00
54.01	03630	ULTRA SOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MRI	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.132340	0	59.00
60.00	06000	LABORATORY	0.117637	1,205,991	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.202532	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.123822	239,230	65.00
66.00	06600	PHYSICAL THERAPY	0.287693	106,648	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.214554	85,162	67.00
68.00	06800	SPEECH PATHOLOGY	0.268479	18,948	68.00
69.00	06900	ELECTROCARDIOLOGY	0.073572	77,601	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.337470	52,349	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.102166	59,237	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117209	2,085,508	73.00
74.00	07400	RENAL DIALYSIS	0.216351	10,892	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.149277	271,257	76.02
76.03	03952	WOUND CARE	0.307400	8,420	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	4.229618	131	90.00
91.00	09100	EMERGENCY	0.125158	286,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.245503	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		5,457,855	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		5,457,855	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150047 Component CCN: 155356	Period: From 06/01/2014 To 05/31/2015	Worksheet D-3 Date/Time Prepared: 10/30/2015 5:01 pm	
		Title XVIII	Skilled Nursing Facility	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
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.118097	1,070	126
50.01	03330	ENDOSCOPY	0.168242	0	0
51.00	05100	RECOVERY ROOM	0.297760	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.185350	0	0
53.00	05300	ANESTHESIOLOGY	0.018658	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088113	108,810	9,588
54.01	03630	ULTRA SOUND	0.000000	0	0
56.00	05600	RADIOISOTOPE	0.000000	0	0
57.00	05700	CT SCAN	0.000000	0	0
58.00	05800	MRI	0.000000	0	0
59.00	05900	CARDIAC CATHETERIZATION	0.132340	0	0
60.00	06000	LABORATORY	0.117637	405,365	47,686
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.202532	3,395	688
65.00	06500	RESPIRATORY THERAPY	0.123822	289,223	35,812
66.00	06600	PHYSICAL THERAPY	0.287693	663,996	191,027
67.00	06700	OCCUPATIONAL THERAPY	0.214554	679,789	145,851
68.00	06800	SPEECH PATHOLOGY	0.268479	30,448	8,175
69.00	06900	ELECTROCARDIOLOGY	0.073572	7,177	528
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.337470	127,227	42,935
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.102166	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117209	1,570,445	184,070
74.00	07400	RENAL DIALYSIS	0.216351	0	0
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0
76.01	03951	SLEEP LAB	0.000000	0	0
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.149277	0	0
76.03	03952	WOUND CARE	0.307400	71,371	21,939
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	4.229618	0	0
91.00	09100	EMERGENCY	0.125158	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.245503	3,277	805
200.00		Total (sum of lines 50-94 and 96-98)		3,961,593	689,230
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00		Net Charges (line 200 minus line 201)		3,961,593	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet D-3 Date/Time Prepared: 10/30/2015 5:01 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		3,935,238	30.00
31.00	03100	INTENSIVE CARE UNIT		298,694	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0	31.01
33.00	03300	BURN INTENSIVE CARE UNIT		1,257,143	33.00
40.00	04000	SUBPROVIDER - I PF		989,875	40.00
43.00	04300	NURSERY		1,869,078	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.118097	2,049,091	241,991 50.00
50.01	03330	ENDOSCOPY	0.168242	100,629	16,930 50.01
51.00	05100	RECOVERY ROOM	0.297760	237,681	70,772 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.185350	439,220	520,629 52.00
53.00	05300	ANESTHESIOLOGY	0.018658	395,556	7,380 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088113	2,336,800	205,902 54.00
54.01	03630	ULTRA SOUND	0.000000	0	0 54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0 56.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MRI	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.132340	665,166	88,028 59.00
60.00	06000	LABORATORY	0.117637	3,634,731	427,579 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.202532	439,750	89,063 62.00
65.00	06500	RESPIRATORY THERAPY	0.123822	1,303,168	161,361 65.00
66.00	06600	PHYSICAL THERAPY	0.287693	153,572	44,182 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.214554	131,910	28,302 67.00
68.00	06800	SPEECH PATHOLOGY	0.268479	110,965	29,792 68.00
69.00	06900	ELECTROCARDIOLOGY	0.073572	112,020	8,242 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.337470	994,484	335,609 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.102166	1,208,255	123,443 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117209	6,271,132	735,033 73.00
74.00	07400	RENAL DIALYSIS	0.216351	157,288	34,029 74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0 76.00
76.01	03951	SLEEP LAB	0.000000	0	0 76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.149277	304,655	45,478 76.02
76.03	03952	WOUND CARE	0.307400	164,020	50,420 76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	4.229618	240	1,015 90.00
91.00	09100	EMERGENCY	0.125158	978,917	122,519 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.245503	81,188	19,932 92.00
200.00		Total (sum of lines 50-94 and 96-98)		22,270,438	3,407,631 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		22,270,438	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet E Part A Date/Time Prepared: 10/30/2015 5:01 pm	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,854,435		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		6,759,485		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)		761,350		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		5,937,253		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		114.12		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)		1.89		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).		9.00		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)		7.11		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		5.14		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)		5.14		12.00
13.00	Total allowable FTE count for the prior year.		5.70		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.		7.11		14.00
15.00	Sum of lines 12 through 14 divided by 3.		5.98		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		5.98		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.052401		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.056159		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.052401		21.00
22.00	IME payment adjustment (see instructions)		438,776		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).		4.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		-1.97		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)		438,776		29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet E Part A Date/Time Prepared: 10/30/2015 5:01 pm		
		Title XVIII	Hospital		PPS	
		0	before 1/1	on/after 1/1	2.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		1.00	1.01		29.01
Disproportionate Share Adjustment						
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		11.07			30.00
31.00	Percentage of Medicaid patient days (see instructions)		25.03			31.00
32.00	Sum of lines 30 and 31		36.10			32.00
33.00	Allowable disproportionate share percentage (see instructions)		19.00			33.00
34.00	Disproportionate share adjustment (see instructions)		456,662			34.00
			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
Uncompensated Care Adjustment						
35.00	Total uncompensated care amount (see instructions)		9,046,380,143		0	35.00
35.01	Factor 3 (see instructions)		0.000229291		0.000000000	35.01
35.02	Hospital uncompensated care payment (if line 34 is zero, enter zero on this line) (see instructions)		2,074,254		1,671,243	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		693,313		1,112,635	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,805,948			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)						
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0			46.00
47.00	Subtotal (see instructions)		13,076,656			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)		13,076,656			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		997,467			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).		148,592			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		14,222,715			59.00
60.00	Primary payer payments		44,724			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		14,177,991			61.00
62.00	Deductibles billed to program beneficiaries		971,804			62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet E Part A Date/Time Prepared: 10/30/2015 5:01 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00
63.00	Coinsurance billed to program beneficiaries		42,352		63.00
64.00	Allowable bad debts (see instructions)		232,565		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		151,167		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		104,083		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		13,315,002		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)		-19,333		70.93
70.94	HRR adjustment amount (see instructions)		-36,806		70.94
70.95	Recovery of accelerated depreciation		0		70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		13,258,863		71.00
71.01	Sequestration adjustment (see instructions)		265,177		71.01
72.00	Interim payments		13,144,445		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)		-150,759		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,543,883		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet E Part A Date/Time Prepared: 10/30/2015 5:01 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1		On/After 10/1
		1.00	1.01	2.00
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0		0
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0		0
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0		0
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000		0.0000
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0		0

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet E Part B Date/Time Prepared: 10/30/2015 5:01 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,436	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,188,104	2.00
3.00	PPS payments		6,102,946	3.00
4.00	Outlier payment (see instructions)		61,525	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)		2,436	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		20,781	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		20,781	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)		20,781	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		18,345	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)		2,436	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)		6,164,471	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		10,319	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,186,212	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		4,970,376	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		59,193	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)		5,029,569	30.00
31.00	Primary payer payments		529	31.00
32.00	Subtotal (line 30 minus line 31)		5,029,040	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)		339,909	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		220,941	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		259,426	36.00
37.00	Subtotal (see instructions)		5,249,981	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)		5,249,981	40.00
40.01	Sequestration adjustment (see instructions)		105,000	40.01
41.00	Interim payments		5,070,436	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		74,545	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: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet E-1
Part I
Date/Time Prepared:
10/30/2015 5:01 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		12,846,815		4,869,146	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	05/31/2015	297,630	05/31/2015	169,290	3.01
3.02			0	05/31/2015	32,000	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)		297,630		201,290	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)		13,144,445		5,070,436	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		74,545	6.01
6.02	SETTLEMENT TO PROGRAM		150,759		0	6.02
7.00	Total Medicare program liability (see instructions)		12,993,686		5,144,981	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: 150047 Component CCN: 15S047		Period: From 06/01/2014 To 05/31/2015		Worksheet E-1 Part I Date/Time Prepared: 10/30/2015 5:01 pm	
		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					0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3,189,439			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0			0	3.01
3.02			0			0	3.02
3.03			0			0	3.03
3.04			0			0	3.04
3.05			0			0	3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0			0	3.50
3.51			0			0	3.51
3.52			0			0	3.52
3.53			0			0	3.53
3.54			0			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,189,439			0	4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0			0	5.01
5.02			0			0	5.02
5.03			0			0	5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0			0	5.50
5.51			0			0	5.51
5.52			0			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		6,021			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		3,195,460			0	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: 150047 Component CCN: 155356	Period: From 06/01/2014 To 05/31/2015	Worksheet E-1 Part I Date/Time Prepared: 10/30/2015 5:01 pm PPS	
		Title XVIII		Skilled Nursing Facility	
		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		618,897		0
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
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		618,897		0
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		1,037		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		619,934		0
		0		Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00
8.00	Name of Contractor				

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet E-1 Part II Date/Time Prepared: 10/30/2015 5:01 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD 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		5,032	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		5,954	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3,822	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		27,747	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		506,659,878	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		1,373,198	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)		245,243	8.00
9.00	Sequestration adjustment amount (see instructions)		4,905	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		240,338	10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		313,914	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)		-73,576	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet E-3 Part II Date/Time Prepared: 10/30/2015 5:01 pm
		Component CCN: 15S047	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)		3,483,393	1.00
2.00	Net IPF PPS Outlier Payments		28,420	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)		23.394521	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)		3,511,813	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)		3,511,813	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		3,511,813	18.00
19.00	Deductibles		233,856	19.00
20.00	Subtotal (line 18 minus line 19)		3,277,957	20.00
21.00	Coinsurance		23,159	21.00
22.00	Subtotal (line 20 minus line 21)		3,254,798	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		9,039	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		5,875	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,684	25.00
26.00	Subtotal (sum of lines 22 and 24)		3,260,673	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)		0	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)		3,260,673	31.00
31.01	Sequestration adjustment (see instructions)		65,213	31.01
32.00	Interim payments		3,189,439	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)		6,021	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		28,420	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: 150047 Component CCN: 155356	Period: From 06/01/2014 To 05/31/2015	Worksheet E-3 Part VI Date/Time Prepared: 10/30/2015 5:01 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		700,669	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		700,669	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		69,141	7.00
8.00	Allowable bad debts (see instructions)		1,628	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		1,058	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		632,586	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (see instructions)		632,586	15.00
15.01	Sequestration adjustment (see instructions)		12,652	15.01
16.00	Interim payments		618,897	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)		1,037	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 10/30/2015 5:01 pm	
		Title XIX	Hospital	PPS	
		Inpatient	Outpatient		
		1.00	2.00		
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	0			1.00
2.00	Medical and other services		2,597,562		2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	2,597,562		4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments		0		6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	2,597,562		7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	0			8.00
9.00	Ancillary service charges	22,270,438	19,735,461		9.00
10.00	Organ acquisition charges, net of revenue	0			10.00
11.00	Incentive from target amount computation	0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	22,270,438	19,735,461		12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0		13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0		14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000		15.00
16.00	Total customary charges (see instructions)	22,270,438	19,735,461		16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	22,270,438	17,137,899		17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0		18.00
19.00	Interns and Residents (see instructions)	0	0		19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0		20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	2,597,562		21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0	0		22.00
23.00	Outlier payments	0	0		23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0	0		26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0		27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	2,597,562		29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	0	0		30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	2,597,562		31.00
32.00	Deductibles	0	0		32.00
33.00	Coinurance	0	0		33.00
34.00	Allowable bad debts (see instructions)	0	0		34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	2,597,562		36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0		37.00
38.00	Subtotal (line 36 ± line 37)	0	2,597,562		38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	2,597,562		40.00
41.00	Interim payments	0	2,597,562		41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0		43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150047 Component CCN: 15S047	Period: From 06/01/2014 To 05/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 10/30/2015 5:01 pm
		Title XIX	Subprovider - IPF	PPS
			Inpatient 1.00	Outpatient 2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		0	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	31.00
32.00	Deductibles		0	32.00
33.00	Coinurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	40.00
41.00	Interim payments		0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet E-4 Date/Time Prepared: 10/30/2015 5:01 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			6.84	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			6.84	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			5.14	6.00
7.00	Enter the lesser of line 5 or line 6			5.14	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	5.14	0.00	5.14	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	5.14	0.00	5.14	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	5.14	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	5.70	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	6.48	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	5.77	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	5.77	0.00		17.00
18.00	Per resident amount	93,148.61	88,203.58		18.00
19.00	Approved amount for resident costs	537,467	0	537,467	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			5.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			92,633.77	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			537,467	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	10,006	4,684		26.00
27.00	Total Inpatient Days (see instructions)	36,286	36,286		27.00
28.00	Ratio of inpatient days to total inpatient days	0.275754	0.129086		28.00
29.00	Program direct GME amount	148,209	69,379		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		9,803		30.00
31.00	Net Program direct GME amount			207,785	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet E-4 Date/Time Prepared: 10/30/2015 5:01 pm
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		2,395,600	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		15,583,588	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		44,724	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		15,538,864	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		6,190,540	42.00
43.00	Primary payer payments (see instructions)		529	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		6,190,011	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		21,728,875	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.715125	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.284875	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		207,785	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		148,592	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		59,193	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) Provider CCN: 150047 Period: From 06/01/2014 To 05/31/2015 Worksheet G
 Date/Time Prepared: 10/30/2015 5:01 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-1,433,757	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	33,232,206	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,064,238	0	0	0	6.00
7.00	Inventory	3,508,186	0	0	0	7.00
8.00	Prepaid expenses	613,593	0	0	0	8.00
9.00	Other current assets	809,940	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)	25,665,930	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,010,000	0	0	0	12.00
13.00	Land improvements	400,981	0	0	0	13.00
14.00	Accumulated depreciation	-316,600	0	0	0	14.00
15.00	Buildings	28,318,373	0	0	0	15.00
16.00	Accumulated depreciation	-11,998,890	0	0	0	16.00
17.00	Leasehold improvements	18,931,472	0	0	0	17.00
18.00	Accumulated depreciation	-4,711,018	0	0	0	18.00
19.00	Fixed equipment	415,382	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	19,579,297	0	0	0	23.00
24.00	Accumulated depreciation	-14,964,269	0	0	0	24.00
25.00	Minor equipment depreciable	7,476,419	0	0	0	25.00
26.00	Accumulated depreciation	-5,386,960	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	38,754,187	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	4,250,620	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,250,620	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	68,670,737	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,446,243	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,290,517	0	0	0	38.00
39.00	Payroll taxes payable	353,166	0	0	0	39.00
40.00	Notes and loans payable (short term)	22,222	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	23,754,032	0	0	0	43.00
44.00	Other current liabilities	2,020,421	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	31,886,601	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	59,259	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)	59,259	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	31,945,860	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	36,724,877				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	36,724,877	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	68,670,737	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet G-1

Date/Time Prepared:
10/30/2015 5:01 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		34,585,911			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		232,180				2.00
3.00	Total (sum of line 1 and line 2)		34,818,091			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		34,818,091			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		34,818,091			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: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet G-2
Parts I & II
Date/Time Prepared:
10/30/2015 5:01 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	38,835,503		38,835,503	1.00
2.00	SUBPROVIDER - IPF	20,283,754		20,283,754	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	3,264,400		3,264,400	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)	62,383,657		62,383,657	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,669,384		3,669,384	11.00
11.01	NEONATAL INTENSIVE CARE UNIT	0		0	11.01
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	6,389,552		6,389,552	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)	10,058,936		10,058,936	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	72,442,593		72,442,593	17.00
18.00	Ancillary services	211,227,986	0	211,227,986	18.00
19.00	Outpatient services	0	222,989,299	222,989,299	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	283,670,579	222,989,299	506,659,878	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		123,522,464		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		123,522,464		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150047

Period:
From 06/01/2014
To 05/31/2015

Worksheet G-3

Date/Time Prepared:
10/30/2015 5:01 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	506,659,878	1.00
2.00	Less contractual allowances and discounts on patients' accounts	381,951,837	2.00
3.00	Net patient revenues (line 1 minus line 2)	124,708,041	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	123,522,464	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,185,577	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	-953,397	24.00
25.00	Total other income (sum of lines 6-24)	-953,397	25.00
26.00	Total (line 5 plus line 25)	232,180	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)	232,180	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150047	Period: From 06/01/2014 To 05/31/2015	Worksheet L Parts I-III Date/Time Prepared: 10/30/2015 5:01 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		764,189	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		158,234	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)		76.02	3.00
4.00	Number of interns & residents (see instructions)		5.98	4.00
5.00	Indirect medical education percentage (see instructions)		2.24	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		17,118	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		11.07	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		25.03	8.00
9.00	Sum of lines 7 and 8		36.10	9.00
10.00	Allowable disproportionate share percentage (see instructions)		7.58	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		57,926	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		997,467	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