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: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S Parts I-III | Date/Time Prepared: 10/28/2016 10:36 am

PART I - COST REPORT STATUS

Provider use only
1. [X] Electronically filed cost report — Date: 10/28/2016 Time: 10:36 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HUNTINGTON MEMORIAL HOSPITAL (150091) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	86,790	47,906	24,141	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	86,790	47,906	24,141	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: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 10/28/2016 10:35 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2001 STULTS ROAD	PO Box:			1.00
2.00	City: HUNTINGTON	State: IN	Zip Code: 46750	County: HUNTINGTON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HUNTINGTON MEMORIAL HOSPITAL	150091	23060	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
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)	01/01/2015	12/31/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(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	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	254	538	0	0	783	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150091	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 10/28/2016 10:35 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2	10/01/2013	27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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

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

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 10/28/2016 10:35 am

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	91,141	0	18,739	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 10/28/2016 10:35 am

		1.00	2.00	
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	15H032	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: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Name: WISCONSIN PHYSICIANS SERVICE	Contractor's Number: 08101	141.00
142.00	Street: 10501 CORPORATE DRIVE	PO Box: 5600		142.00
143.00	City: FORT WAYNE	State: IN	Zip Code: 46895-5600	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.25	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150091	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 10/28/2016 10:35 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2015	12/31/2015	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. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)	N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 10/28/2016 10:35 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/23/2016	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	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)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/16/2016	Y	03/16/2016	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.	Y		Y		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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150091	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 10/28/2016 10:35 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
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

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	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.	N		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.	ERIC	NICKESON	41.00
42.00	Enter the employer/company name of the cost report preparer.	PARKVIEW HEALTH SYSTEM, INC.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(260) 373-8406	ERIC.NICKESON@PARKVIEW.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150091	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 10/28/2016 10:35 am

		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.	DIRECTOR, REIMBURSEMENT		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: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 10/28/2016 10:35 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 10/28/2016 10:35 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,424	176	4,491			1.00
2.00	HMO and other (see instructions)	1,148	1,275				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,424	176	4,491			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		71	725			13.00
14.00	Total (see instructions)	1,424	247	5,216	0.00	205.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	205.00	27.00
28.00	Observation Bed Days		234	1,053			28.00
29.00	Ambulance Trips	1,233					29.00
30.00	Employee discount days (see instruction)			102			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	53	89			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: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 10/28/2016 10:35 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	470	537	1,607	1.00
2.00	HMO and other (see instructions)			373	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	470	537	1,607	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						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: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 10/28/2016 10:35 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	13,332,706	3,516,096	16,848,802	566,292.00	29.75	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		24,000	0	24,000	199.00	120.60	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		4,424,639	0	4,424,639	116,724.00	37.91	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,492,729	245,828	1,738,557	78,606.00	22.12	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		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		4,424,639	0	4,424,639	116,724.00	37.91	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)		4,474,907	0	4,474,907			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		668,785	0	668,785			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	1,310,130	-1,310,130	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	2,008,501	3,543,187	5,551,688	158,526.00	35.02	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	294,525	39,514	334,039	12,713.00	26.28	30.00
31.00	Laundry & Linen Service	8.00	0	32,347	32,347	2,584.00	12.52	31.00
32.00	Housekeeping	9.00	281,214	5,381	286,595	23,257.00	12.32	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	353,141	-287,815	65,326	5,854.00	11.16	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	229,178	229,178	17,356.00	13.20	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	174,528	23,415	197,943	4,987.00	39.69	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	534,626	768	535,394	10,398.00	51.49	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 10/28/2016 10:35 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	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: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part III Date/Time Prepared: 10/28/2016 10:35 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		8,908,067	3,516,096	12,424,163	449,568.00	27.64	1.00
2.00	Excluded area salaries (see instructions)		1,492,729	245,828	1,738,557	78,606.00	22.12	2.00
3.00	Subtotal salaries (line 1 minus line 2)		7,415,338	3,270,268	10,685,606	370,962.00	28.81	3.00
4.00	Subtotal other wages & related costs (see inst.)		4,424,639	0	4,424,639	116,724.00	37.91	4.00
5.00	Subtotal wage-related costs (see inst.)		4,474,907	0	4,474,907	0.00	41.88	5.00
6.00	Total (sum of lines 3 thru 5)		16,314,884	3,270,268	19,585,152	487,686.00	40.16	6.00
7.00	Total overhead cost (see instructions)		4,956,665	2,275,845	7,232,510	235,675.00	30.69	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 10/28/2016 10:35 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	327,571	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	312,516	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	52,689	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2,995,829	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	26,049	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	65,144	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	28,855	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	1,257,876	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	47,001	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	30,162	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,143,692	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part V Date/Time Prepared: 10/28/2016 10:35 am

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-10 Date/Time Prepared: 10/28/2016 10:35 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.232849	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,502,332	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	3,885,308	5.00
6.00	Medicaid charges	27,772,924	6.00
7.00	Medicaid cost (line 1 times line 6)	6,466,898	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)	1,079,258	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	13,381	9.00
10.00	Stand-alone SCHIP charges	113,067	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	26,328	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	12,947	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)	1,102,156	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	9,548,691	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	2,223,403	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)	1,121,247	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)	2,213,452	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	1,939,872	765,722	2,705,594	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	451,697	178,298	629,995	21.00
22.00	Partial payment by patients approved for charity care	221	3,698	3,919	22.00
23.00	Cost of charity care (line 21 minus line 22)	451,476	174,600	626,076	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	7,340,468	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	68,601	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	7,271,867	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,693,247	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,319,323	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,532,775	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		814,062	814,062	-655,078	158,984	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	802,086	802,086	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,310,130	3,980,752	5,290,882	-1,310,130	3,980,752	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,008,501	12,515,599	14,524,100	-130,493	14,393,607	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	294,525	832,355	1,126,880	39,167	1,166,047	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	145,077	145,077	32,347	177,424	8.00
9.00	00900	HOUSEKEEPING	281,214	121,771	402,985	5,381	408,366	9.00
10.00	01000	DIETARY	353,141	306,849	659,990	-495,000	164,990	10.00
11.00	01100	CAFETERIA	0	6,336	6,336	404,104	410,440	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	174,528	7,557	182,085	23,415	205,500	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	534,626	988,210	1,522,836	-11,435	1,511,401	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,842,050	311,877	3,153,927	-350,516	2,803,411	30.00
43.00	04300	NURSERY	0	0	0	39,403	39,403	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	818,013	445,961	1,263,974	84,633	1,348,607	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	690,974	690,974	52.00
53.00	05300	ANESTHESIOLOGY	0	737,309	737,309	0	737,309	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	799,536	487,013	1,286,549	94,397	1,380,946	54.00
60.00	06000	LABORATORY	0	1,857,961	1,857,961	-232	1,857,729	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	553,103	118,818	671,921	72,725	744,646	65.00
66.00	06600	PHYSICAL THERAPY	898,333	78,811	977,144	-178,528	798,616	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	196,710	196,710	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	79,014	79,014	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,594	8,594	0	8,594	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,456,915	1,456,915	-765,120	691,795	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	764,734	764,734	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,679,481	1,679,481	68,226	1,747,707	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	972,277	180,618	1,152,895	106,536	1,259,431	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,390,932	215,068	1,606,000	179,434	1,785,434	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		-1,953	-1,953	0	-1,953	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,230,909	27,295,041	40,525,950	-213,246	40,312,704	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,077	259,669	318,746	7,500	326,246	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	-49,599	-49,599	49,599	0	194.02
194.03	07953	FOUNDATIO	0	86,900	86,900	0	86,900	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	42,720	422,311	465,031	-1,350	463,681	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	90,756	90,756	194.07
194.08	07958	AUTISM CENTER	0	0	0	66,741	66,741	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		TOTAL (SUM OF LINES 118-199)	13,332,706	28,014,322	41,347,028	0	41,347,028	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	55,771	214,755	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-57,153	744,933	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,757,666	2,223,086	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,025,663	12,367,944	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-1,323	1,164,724	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	177,424	8.00
9.00	00900	HOUSEKEEPING	0	408,366	9.00
10.00	01000	DIETARY	-16,199	148,791	10.00
11.00	01100	CAFETERIA	-215,465	194,975	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	205,500	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-1,296,976	214,425	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	28,152	2,831,563	30.00
43.00	04300	NURSERY	0	39,403	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-675,873	672,734	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	690,974	52.00
53.00	05300	ANESTHESIOLOGY	0	737,309	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,380,946	54.00
60.00	06000	LABORATORY	0	1,857,729	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-60,120	684,526	65.00
66.00	06600	PHYSICAL THERAPY	-15,236	783,380	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	196,710	67.00
68.00	06800	SPEECH PATHOLOGY	0	79,014	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,594	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	691,795	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	764,734	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,747,707	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	-15,000	1,244,431	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	-23,830	1,761,604	95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	1,953	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,074,628	34,238,076	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-244,153	82,093	192.00
194.00	07950	OCC HEALTH	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	194.01
194.02	07952	OCC HEALTH	0	0	194.02
194.03	07953	FOUNDATIO	0	86,900	194.03
194.04	07954	KIDS CAMPUS	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	463,681	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	194.06
194.07	07957	MISC CATERING	0	90,756	194.07
194.08	07958	AUTISM CENTER	0	66,741	194.08
194.09	07959	HUNTINGTON BUA	0	0	194.09
200.00		TOTAL (SUM OF LINES 118-199)	-6,318,781	35,028,247	200.00

RECLASSIFICATIONS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 10/28/2016 10:35 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA AND CATERING				
1.00	CAFETERIA	11.00	229,178	174,926	1.00
2.00	MISC CATERING	194.07	51,294	39,462	2.00
	0		280,472	214,388	
	D - DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	685,235	1.00
	0		0	685,235	
	E - BUILDING AND EQUIPMENT				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	90,707	1.00
2.00	AUTISM CENTER	194.08	0	66,741	2.00
3.00		0.00	0	0	3.00
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
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
	0		0	157,448	
	F - INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	30,157	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	26,144	2.00
	0		0	56,301	
	G - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	32,347	0	1.00
	0		32,347	0	
	H - HOME OFFICE SALARY				
1.00	ADMINISTRATIVE & GENERAL	5.00	3,524,581	0	1.00
	0		3,524,581	0	
	I - PTO				
1.00	ADMINISTRATIVE & GENERAL	5.00	19,748	0	1.00
2.00	OPERATION OF PLANT	7.00	39,514	0	2.00
3.00	HOUSEKEEPING	9.00	37,728	0	3.00
4.00	NURSING ADMINISTRATION	13.00	23,415	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	381,288	0	5.00
6.00	OPERATING ROOM	50.00	109,745	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	107,266	0	7.00
8.00	RESPIRATORY THERAPY	65.00	74,204	0	8.00
9.00	PHYSICAL THERAPY	66.00	120,521	0	9.00
10.00	DRUGS CHARGED TO PATIENTS	73.00	70,958	0	10.00
11.00	EMERGENCY	91.00	130,441	0	11.00
12.00	AMBULANCE SERVICES	95.00	186,608	0	12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	7,926	0	13.00
14.00	PHARMACY	15.00	768	0	14.00
	0		1,310,130	0	
	J - SALARY				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,142	1.00
2.00	DIETARY	10.00	0	7,343	2.00
	0		0	8,485	
	K - OCC HEALTH				
1.00	OCC HEALTH	194.02	0	49,599	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	0		0	49,599	
	L - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	764,734	1.00
	0		0	764,734	
	M - OB				
1.00	NURSERY	43.00	35,569	3,834	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	623,739	67,235	2.00
	0		659,308	71,069	
	O - THERAPY				
1.00	OCCUPATIONAL THERAPY	67.00	180,844	15,866	1.00
2.00	SPEECH PATHOLOGY	68.00	72,642	6,372	2.00
	TOTALS		253,486	22,238	
500.00	Grand Total: Increases		6,060,324	2,029,497	500.00

RECLASSIFICATIONS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 10/28/2016 10:35 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA AND CATERING					
1.00	DIETARY	10.00	280,472	214,388	0	1.00
2.00		0.00	0	0	0	2.00
	0		280,472	214,388		
	D - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	685,235	9	1.00
	0		0	685,235		
	E - BUILDING AND EQUIPMENT					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	93,940	10	1.00
2.00	OPERATION OF PLANT	7.00	0	347	0	2.00
3.00	DIETARY	10.00	0	140	0	3.00
5.00	PHARMACY	15.00	0	12,203	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	1,427	0	6.00
7.00	OPERATING ROOM	50.00	0	20,410	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	117	0	8.00
9.00	RESPIRATORY THERAPY	65.00	0	1,479	0	9.00
10.00	PHYSICAL THERAPY	66.00	0	17,023	0	10.00
12.00	EMERGENCY	91.00	0	1,412	0	12.00
13.00	AMBULANCE SERVICES	95.00	0	7,174	0	13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	426	0	14.00
15.00	COMMUNITY & VOLUNTEER SERVICES	194.05	0	1,350	0	15.00
	0		0	157,448		
	F - INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	56,301	9	1.00
2.00		0.00	0	0	9	2.00
	0		0	56,301		
	G - LAUNDRY					
1.00	HOUSEKEEPING	9.00	32,347	0	0	1.00
	0		32,347	0		
	H - HOME OFFICE SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,524,581	0	1.00
	0		0	3,524,581		
	I - PTO					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,310,130	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
	0		1,310,130	0		
	J - SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	1,142	0	0	1.00
2.00	DIETARY	10.00	7,343	0	0	2.00
	0		8,485	0		
	K - OCC HEALTH					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,752	0	1.00
2.00	LABORATORY	60.00	0	232	0	2.00
3.00	PHYSICAL THERAPY	66.00	0	6,302	0	3.00
4.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	386	0	4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,732	0	5.00
6.00	EMERGENCY	91.00	0	22,493	0	6.00
7.00	OPERATING ROOM	50.00	0	4,702	0	7.00
	0		0	49,599		
	L - IMPLANTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	764,734	0	1.00
	0		0	764,734		
	M - OB					
1.00	ADULTS & PEDIATRICS	30.00	659,308	71,069	0	1.00
2.00		0.00	0	0	0	2.00
	0		659,308	71,069		

RECLASSIFICATIONS

Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 10/28/2016 10:35 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	O - THERAPY						
1.00	PHYSICAL THERAPY	66.00	253,486	22,238	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		253,486	22,238			
500.00	Grand Total: Decreases		2,544,228	5,545,593			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I Date/Time Prepared: 10/28/2016 10:35 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	465,871	0	0	0	0	2.00
3.00	Buildings and Fixtures	1,641,580	285,515	0	285,515	0	3.00
4.00	Building Improvements	32,500	0	0	0	0	4.00
5.00	Fixed Equipment	1,249,874	538	0	538	0	5.00
6.00	Movable Equipment	10,565,636	238,188	0	238,188	1,300	6.00
7.00	HIT designated Assets	2,539,169	203,630	0	203,630	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,494,630	727,871	0	727,871	1,300	8.00
9.00	Reconciling Items	2,353,119	232,897	0	232,897	0	9.00
10.00	Total (line 8 minus line 9)	14,141,511	494,974	0	494,974	1,300	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	465,871	128,649	2.00
3.00	Buildings and Fixtures	1,927,095	138,882	3.00
4.00	Building Improvements	32,500	0	4.00
5.00	Fixed Equipment	1,250,412	530,253	5.00
6.00	Movable Equipment	10,802,524	7,003,581	6.00
7.00	HIT designated Assets	2,742,799	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,221,201	7,801,365	8.00
9.00	Reconciling Items	2,586,016	0	9.00
10.00	Total (line 8 minus line 9)	14,635,185	7,801,365	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 10/28/2016 10:35 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	814,062	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)	814,062	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	814,062	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	814,062	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 10/28/2016 10:35 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	3,675,878	0	3,675,878	0.260400	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,802,524	362,132	10,440,392	0.739600	0	2.00
3.00	Total (sum of lines 1-2)	14,478,402	362,132	14,116,270	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	214,755	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	654,226	90,707	2.00
3.00	Total (sum of lines 1-2)	0	0	0	868,981	90,707	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	0	0	0	0	214,755	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	744,933	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	959,688	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 10/28/2016 10:35 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,007	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-493	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	-704,720			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,106,281			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	A	-39,671	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		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	A	-7,343	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 10/28/2016 10:35 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	TELEPHONE SERVICES	A	-341	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	VENDING	A	-2,192	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	VENDING	A	-830	OPERATION OF PLANT	7.00	0	33.03
33.04	RENT	A	-964,968	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	RENT	A	-18,187	RESPIRATORY THERAPY	65.00	0	33.05
33.06	RENT	A	-244,153	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.06
33.07	PHARMACY EMPLOYEE PURCHASES	B	-712,644	PHARMACY	15.00	0	33.07
33.08	PHYSICIAN RECRUITMENT	A	-25,000	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.10	SELF INSURANCE	A	-1,755,133	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	GUEST MEALS	A	-23,415	CAFETERIA	11.00	0	33.11
33.12	CONSULTING PT	B	-365	PHYSICAL THERAPY	66.00	0	33.12
33.13	LOBBY DUES	A	-3,411	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	LIQUOR	A	-1,559	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.18	OTHER OPERATING REVENUE	B	-8,881	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	OTHER OPERATING REVENUE	B	-8,856	DIETARY	10.00	0	33.19
33.20	OTHER OPERATING REVENUE	B	-152,379	CAFETERIA	11.00	0	33.20
33.21	OTHER OPERATING REVENUE	B	-584,332	PHARMACY	15.00	0	33.21
33.24	OTHER OPERATING REVENUE	B	-35,459	RESPIRATORY THERAPY	65.00	0	33.24
33.25	OTHER OPERATING REVENUE	B	-14,871	PHYSICAL THERAPY	66.00	0	33.25
33.27	OTHER OPERATING REVENUE	B	-8,830	AMBULANCE SERVICES	95.00	0	33.27
33.29	TELEMETRY	A	29,163	ADULTS & PEDIATRICS	30.00	0	33.29
33.30	OTHER OPERATING REVENUE	B	-1,011	ADULTS & PEDIATRICS	30.00	0	33.30
33.31	OTHER OPERATING REVENUE	B	-7,627	OPERATING ROOM	50.00	0	33.31
34.00	DEPRECIATION	A	55,771	CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
35.00	DEPRECIATION	A	-57,153	CAP REL COSTS-MVBLE EQUIP	2.00	9	35.00
36.00	INTEREST EXPENSE	A	1,953	INTEREST EXPENSE	113.00	0	36.00
37.00	PHYS ADMIN SALARIES	A	86,444	ADMINISTRATIVE & GENERAL	5.00	0	37.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,318,781				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: 150091	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-1 Date/Time Prepared: 10/28/2016 10:35 am

	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	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATIONS	9,008,499	7,620,000	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	PPG SUBSIDY	0	2,494,780	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,008,499	10,114,780	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	PARKVIEW HEALTH SYSTEM, INC.	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(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: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 10/28/2016 10:35 am

	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	1,388,499	0	1.00
2.00	-2,494,780	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	-1,106,281		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	HOME OFFICE	6.00
7.00		7.00
8.00		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: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 10/28/2016 10:35 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	691,150	667,150	24,000	239,400	199	1.00
2.00	65.00	RESPIRATORY THERAPY	6,474	6,474	0	0	0	2.00
3.00	91.00	EMERGENCY	15,000	15,000	0	0	0	3.00
4.00	95.00	AMBULANCE SERVICES	15,000	15,000	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			727,624	703,624	24,000		199	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	50.00	OPERATING ROOM	22,904	1,145	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			22,904	1,145	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	50.00	OPERATING ROOM	0	22,904	1,096	668,246	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	6,474	2.00
3.00	91.00	EMERGENCY	0	0	0	15,000	3.00
4.00	95.00	AMBULANCE SERVICES	0	0	0	15,000	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	22,904	1,096	704,720	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	214,755	214,755				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	744,933		744,933			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,223,086	243	0	2,223,329		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,367,944	14,144	19,037	732,585	13,133,710	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,164,724	56,484	30,976	44,079	1,296,263	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	177,424	1,158	0	4,268	182,850	8.00
9.00	00900	HOUSEKEEPING	408,366	943	0	37,819	447,128	9.00
10.00	01000	DIETARY	148,791	9,008	4,261	8,620	170,680	10.00
11.00	01100	CAFETERIA	194,975	2,044	0	30,242	227,261	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	205,500	0	0	26,120	231,620	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,508	0	0	3,508	14.00
15.00	01500	PHARMACY	214,425	2,127	94,721	70,650	381,923	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,175	0	0	1,175	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,831,563	46,331	119,481	338,344	3,335,719	30.00
43.00	04300	NURSERY	39,403	188	0	4,694	44,285	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	672,734	17,649	0	122,425	812,808	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	690,974	0	0	82,307	773,281	52.00
53.00	05300	ANESTHESIOLOGY	737,309	0	0	0	737,309	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,380,946	22,120	221,178	119,660	1,743,904	54.00
60.00	06000	LABORATORY	1,857,729	3,351	0	0	1,861,080	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	684,526	2,479	39,354	82,778	809,137	65.00
66.00	06600	PHYSICAL THERAPY	783,380	15,328	13,113	100,996	912,817	66.00
67.00	06700	OCCUPATIONAL THERAPY	196,710	0	0	23,864	220,574	67.00
68.00	06800	SPEECH PATHOLOGY	79,014	0	0	9,586	88,600	68.00
69.00	06900	ELECTROCARDIOLOGY	8,594	0	0	0	8,594	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	691,795	0	0	0	691,795	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	764,734	0	0	0	764,734	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,747,707	0	0	9,363	1,757,070	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,244,431	9,428	40,762	145,512	1,440,133	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,761,604	6,539	156,286	208,169	2,132,598	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	34,238,076	214,247	739,169	2,202,081	34,210,556	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	82,093	0	5,764	8,842	96,699	192.00
194.00	07950	OCC HEALTH	0	508	0	0	508	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	86,900	0	0	0	86,900	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	463,681	0	0	5,637	469,318	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	90,756	0	0	6,769	97,525	194.07
194.08	07958	AUTISM CENTER	66,741	0	0	0	66,741	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	35,028,247	214,755	744,933	2,223,329	35,028,247	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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
5.00	00500	ADMINISTRATIVE & GENERAL	13,133,710					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	777,579	0	2,073,842			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	109,685	0	16,695	309,230		8.00
9.00	00900	HOUSEKEEPING	268,215	0	13,589	2,053	730,985	9.00
10.00	01000	DIETARY	102,384	0	129,841	0	46,444	10.00
11.00	01100	CAFETERIA	136,325	0	29,461	0	10,538	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	138,940	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,104	0	50,561	3,278	18,086	14.00
15.00	01500	PHARMACY	229,101	0	30,655	0	10,965	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	705	0	16,933	0	6,057	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,000,978	0	667,784	92,072	238,869	30.00
43.00	04300	NURSERY	26,565	0	2,707	3,150	968	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	487,573	0	254,373	54,140	90,990	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	463,862	0	0	22,745	0	52.00
53.00	05300	ANESTHESIOLOGY	442,284	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,046,102	0	318,816	24,307	114,041	54.00
60.00	06000	LABORATORY	1,116,391	0	48,305	0	17,279	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	485,371	0	35,725	20,461	12,779	65.00
66.00	06600	PHYSICAL THERAPY	547,564	0	220,931	0	79,027	66.00
67.00	06700	OCCUPATIONAL THERAPY	132,314	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	53,148	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,155	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	414,982	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	458,735	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,054,000	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	863,881	0	135,892	77,822	48,609	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,279,265	0	94,249	5,659	33,713	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,643,208	0	2,066,517	305,687	728,365	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	58,006	0	0	3,543	0	192.00
194.00	07950	OCC HEALTH	305	0	7,325	0	2,620	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	52,128	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	281,526	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	58,502	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	40,035	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
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)	13,133,710	0	2,073,842	309,230	730,985	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	449,349					10.00
11.00	01100	CAFETERIA	0	403,585				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	5,818	0	376,378		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	77,537	14.00
15.00	01500	PHARMACY	0	12,130	0	0	938	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	449,349	95,118	0	180,691	6,185	30.00
43.00	04300	NURSERY	0	1,350	0	2,564	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	34,971	0	66,434	9,265	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	23,669	0	44,964	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,463	0	0	1,972	54.00
60.00	06000	LABORATORY	0	0	0	0	22	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	26,404	0	0	2,752	65.00
66.00	06600	PHYSICAL THERAPY	0	33,944	0	0	851	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	47,171	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,097	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	43,020	0	81,725	3,852	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	78,461	0	0	3,104	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	449,349	390,348	0	376,378	77,209	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,917	0	0	310	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	2,426	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	2,362	0	0	18	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	4,532	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
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)	449,349	403,585	0	376,378	77,537	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
		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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	665,712					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,870				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,471	0	0	0	30.00
43.00	04300	NURSERY	0	161	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,310	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	592	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	511	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,434	0	0	0	54.00
60.00	06000	LABORATORY	0	2,559	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	875	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	590	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	161	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	64	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	142	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,677	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	665,712	911	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,257	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	3,047	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,108	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	665,712	24,870	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
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)	665,712	24,870	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	7,068,236	0	30.00
43.00	04300	NURSERY	0	0	0	81,750	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,813,864	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,329,113	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,180,104	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,290,039	0	54.00
60.00	06000	LABORATORY	0	0	0	3,045,636	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,393,504	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,795,724	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	353,049	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	141,812	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,891	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,155,625	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,890,092	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,814,424	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	2,697,981	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	3,628,157	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	33,693,001	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	162,475	0	192.00
194.00	07950	OCC HEALTH	0	0	0	10,758	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	0	141,454	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	753,224	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	160,559	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	106,776	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	0	35,028,247	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	7,068,236	30.00
43.00	04300	NURSERY	81,750	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	1,813,864	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,329,113	52.00
53.00	05300	ANESTHESIOLOGY	1,180,104	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,290,039	54.00
60.00	06000	LABORATORY	3,045,636	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,393,504	65.00
66.00	06600	PHYSICAL THERAPY	1,795,724	66.00
67.00	06700	OCCUPATIONAL THERAPY	353,049	67.00
68.00	06800	SPEECH PATHOLOGY	141,812	68.00
69.00	06900	ELECTROCARDIOLOGY	13,891	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,155,625	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,890,092	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,814,424	73.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	2,697,981	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	3,628,157	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	33,693,001	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	162,475	192.00
194.00	07950	OCC HEALTH	10,758	194.00
194.01	07951	PAIN CLINIC	0	194.01
194.02	07952	OCC HEALTH	0	194.02
194.03	07953	FOUNDATIO	141,454	194.03
194.04	07954	KIDS CAMPUS	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	753,224	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	194.06
194.07	07957	MISC CATERING	160,559	194.07
194.08	07958	AUTISM CENTER	106,776	194.08
194.09	07959	HUNTINGTON BUA	0	194.09
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	35,028,247	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		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	243	0	243	243	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,264,702	14,144	19,037	2,297,883	84	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	56,484	30,976	87,460	5	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,158	0	1,158	0	8.00
9.00	00900	HOUSEKEEPING	0	943	0	943	4	9.00
10.00	01000	DIETARY	0	9,008	4,261	13,269	1	10.00
11.00	01100	CAFETERIA	0	2,044	0	2,044	3	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	3	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,508	0	3,508	0	14.00
15.00	01500	PHARMACY	0	2,127	94,721	96,848	7	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,175	0	1,175	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	46,331	119,481	165,812	36	30.00
43.00	04300	NURSERY	0	188	0	188	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	17,649	0	17,649	13	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	9	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,120	221,178	243,298	13	54.00
60.00	06000	LABORATORY	0	3,351	0	3,351	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,479	39,354	41,833	9	65.00
66.00	06600	PHYSICAL THERAPY	0	15,328	13,113	28,441	11	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	3	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	9,428	40,762	50,190	15	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	6,539	156,286	162,825	22	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,264,702	214,247	739,169	3,218,118	240	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	5,764	5,764	1	192.00
194.00	07950	OCC HEALTH	0	508	0	508	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	1	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	0	1	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,264,702	214,755	744,933	3,224,390	243	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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
5.00	00500	ADMINISTRATIVE & GENERAL	2,297,967					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	136,051	0	223,516			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,191	0	1,799	22,148		8.00
9.00	00900	HOUSEKEEPING	46,929	0	1,465	147	49,488	9.00
10.00	01000	DIETARY	17,914	0	13,994	0	3,144	10.00
11.00	01100	CAFETERIA	23,852	0	3,175	0	713	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	24,310	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	368	0	5,449	235	1,224	14.00
15.00	01500	PHARMACY	40,085	0	3,304	0	742	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	123	0	1,825	0	410	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	350,107	0	71,973	6,594	16,173	30.00
43.00	04300	NURSERY	4,648	0	292	226	66	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	85,309	0	27,416	3,878	6,160	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	81,160	0	0	1,629	0	52.00
53.00	05300	ANESTHESIOLOGY	77,385	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	183,033	0	34,362	1,741	7,721	54.00
60.00	06000	LABORATORY	195,332	0	5,206	0	1,170	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	84,924	0	3,850	1,465	865	65.00
66.00	06600	PHYSICAL THERAPY	95,806	0	23,812	0	5,350	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,151	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,299	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	902	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	72,608	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,263	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	184,415	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	151,151	0	14,646	5,574	3,291	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	223,829	0	10,158	405	2,282	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,212,145	0	222,726	21,894	49,311	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,149	0	0	254	0	192.00
194.00	07950	OCC HEALTH	53	0	790	0	177	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	9,121	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	49,258	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	10,236	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	7,005	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
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)	2,297,967	0	223,516	22,148	49,488	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	48,322					10.00
11.00	01100	CAFETERIA	0	29,787				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	429	0	24,742		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	10,784	14.00
15.00	01500	PHARMACY	0	895	0	0	130	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,322	7,022	0	11,878	860	30.00
43.00	04300	NURSERY	0	100	0	169	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,581	0	4,367	1,288	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,747	0	2,956	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,617	0	0	274	54.00
60.00	06000	LABORATORY	0	0	0	0	3	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,949	0	0	383	65.00
66.00	06600	PHYSICAL THERAPY	0	2,505	0	0	118	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	6,562	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	153	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	3,175	0	5,372	536	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,791	0	0	432	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	48,322	28,811	0	24,742	10,739	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	289	0	0	43	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	179	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	174	0	0	2	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	334	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
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)	48,322	29,787	0	24,742	10,784	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
		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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	142,011					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,533				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	205	0			30.00
43.00	04300	NURSERY	0	23	0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	462	0			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	83	0			52.00
53.00	05300	ANESTHESIOLOGY	0	71	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	821	0			54.00
60.00	06000	LABORATORY	0	357	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	122	0			65.00
66.00	06600	PHYSICAL THERAPY	0	82	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	22	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	9	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	20	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	234	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	142,011	127	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	315	0			73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	425	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	155	0			95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	142,011	3,533	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
194.00	07950	OCC HEALTH	0	0	0			194.00
194.01	07951	PAIN CLINIC	0	0	0			194.01
194.02	07952	OCC HEALTH	0	0	0			194.02
194.03	07953	FOUNDATIO	0	0	0			194.03
194.04	07954	KIDS CAMPUS	0	0	0			194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0			194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0			194.06
194.07	07957	MISC CATERING	0	0	0			194.07
194.08	07958	AUTISM CENTER	0	0	0			194.08
194.09	07959	HUNTINGTON BUA	0	0	0			194.09
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)	142,011	3,533	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				678,982	0	30.00
43.00	04300	NURSERY				5,712	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM				149,123	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				87,584	0	52.00
53.00	05300	ANESTHESIOLOGY				77,456	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				473,880	0	54.00
60.00	06000	LABORATORY				205,419	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				135,400	0	65.00
66.00	06600	PHYSICAL THERAPY				156,125	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				23,176	0	67.00
68.00	06800	SPEECH PATHOLOGY				9,309	0	68.00
69.00	06900	ELECTROCARDIOLOGY				922	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				79,404	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				222,401	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				184,884	0	73.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY				234,375	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				405,899	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	3,130,051	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				16,500	0	192.00
194.00	07950	OCC HEALTH				1,528	0	194.00
194.01	07951	PAIN CLINIC				0	0	194.01
194.02	07952	OCC HEALTH				0	0	194.02
194.03	07953	FOUNDATIO				9,300	0	194.03
194.04	07954	KIDS CAMPUS				0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES				49,435	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE				0	0	194.06
194.07	07957	MISC CATERING				10,571	0	194.07
194.08	07958	AUTISM CENTER				7,005	0	194.08
194.09	07959	HUNTINGTON BUA				0	0	194.09
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	0	3,224,390	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	678,982	30.00
43.00	04300	NURSERY	5,712	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	149,123	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	87,584	52.00
53.00	05300	ANESTHESIOLOGY	77,456	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	473,880	54.00
60.00	06000	LABORATORY	205,419	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	135,400	65.00
66.00	06600	PHYSICAL THERAPY	156,125	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,176	67.00
68.00	06800	SPEECH PATHOLOGY	9,309	68.00
69.00	06900	ELECTROCARDIOLOGY	922	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	79,404	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	222,401	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	184,884	73.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	234,375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	405,899	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,130,051	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,500	192.00
194.00	07950	OCC HEALTH	1,528	194.00
194.01	07951	PAIN CLINIC	0	194.01
194.02	07952	OCC HEALTH	0	194.02
194.03	07953	FOUNDATIO	9,300	194.03
194.04	07954	KIDS CAMPUS	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	49,435	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	194.06
194.07	07957	MISC CATERING	10,571	194.07
194.08	07958	AUTISM CENTER	7,005	194.08
194.09	07959	HUNTINGTON BUA	0	194.09
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	3,224,390	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	116,622					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		587,106				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	132	0	16,848,802			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,681	15,004	5,551,688	-13,133,710	21,894,537	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	30,673	24,413	334,039	0	1,296,263	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	629	0	32,347	0	182,850	8.00
9.00	00900	HOUSEKEEPING	512	0	286,595	0	447,128	9.00
10.00	01000	DIETARY	4,892	3,358	65,326	0	170,680	10.00
11.00	01100	CAFETERIA	1,110	0	229,178	0	227,261	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	197,943	0	231,620	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,905	0	0	0	3,508	14.00
15.00	01500	PHARMACY	1,155	74,653	535,394	0	381,923	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	638	0	0	0	1,175	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,160	94,167	2,564,030	0	3,335,719	30.00
43.00	04300	NURSERY	102	0	35,569	0	44,285	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,584	0	927,758	0	812,808	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	623,739	0	773,281	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	737,309	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,012	174,317	906,802	0	1,743,904	54.00
60.00	06000	LABORATORY	1,820	0	0	0	1,861,080	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,346	31,016	627,307	0	809,137	65.00
66.00	06600	PHYSICAL THERAPY	8,324	10,335	765,368	0	912,817	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	180,844	0	220,574	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	72,642	0	88,600	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	8,594	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	691,795	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	764,734	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	70,958	0	1,757,070	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,120	32,126	1,102,718	0	1,440,133	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,551	123,174	1,577,540	0	2,132,598	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	116,346	582,563	16,687,785	-13,133,710	21,076,846	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,543	67,003	0	96,699	192.00
194.00	07950	OCC HEALTH	276	0	0	0	508	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	0	0	86,900	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	42,720	0	469,318	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	51,294	0	97,525	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	66,741	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	214,755	744,933	2,223,329		13,133,710	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.841462	1.268822	0.131958		0.599862	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			243		2,297,967	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000014		0.104956	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	78,136				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	629	251,698			8.00
9.00	00900	HOUSEKEEPING	0	512	1,671	76,995		9.00
10.00	01000	DIETARY	0	4,892	0	4,892	25,077	10.00
11.00	01100	CAFETERIA	0	1,110	0	1,110	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,905	2,668	1,905	0	14.00
15.00	01500	PHARMACY	0	1,155	0	1,155	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	638	0	638	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	25,160	74,943	25,160	25,077	30.00
43.00	04300	NURSERY	0	102	2,564	102	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,584	44,067	9,584	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	18,513	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,012	19,785	12,012	0	54.00
60.00	06000	LABORATORY	0	1,820	0	1,820	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,346	16,654	1,346	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,324	0	8,324	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	5,120	63,343	5,120	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,551	4,606	3,551	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	77,860	248,814	76,719	25,077	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,884	0	0	192.00
194.00	07950	OCC HEALTH	0	276	0	276	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	2,073,842	309,230	730,985	449,349	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	26.541441	1.228576	9.493928	17.918770	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	223,516	22,148	49,488	48,322	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	2.860602	0.087994	0.642743	1.926945	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	CAFETERIA (HOURS OF SERVICE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	345,963					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	4,987	0	169,839			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,394,739		14.00
15.00	01500	PHARMACY	10,398	0	0	28,979	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	81,536	0	81,536	191,031	0	30.00
43.00	04300	NURSERY	1,157	0	1,157	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,978	0	29,978	286,140	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,290	0	20,290	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,400	0	0	60,892	0	54.00
60.00	06000	LABORATORY	0	0	0	680	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	22,634	0	0	84,996	0	65.00
66.00	06600	PHYSICAL THERAPY	29,098	0	0	26,283	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,456,915	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	100	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	33,884	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	36,878	0	36,878	118,956	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	67,259	0	0	95,878	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	334,615	0	169,839	2,384,634	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,358	0	0	9,562	0	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	2,080	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	2,025	0	0	543	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	3,885	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	403,585	0	376,378	77,537	665,712	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.166555	0.000000	2.216087	0.032378	6,657.120000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	29,787	0	24,742	10,784	142,011	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	CAFETERIA (HOURS OF SERVICE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.086099	0.000000	0.145679	0.004503	1,420.110000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	144,698,821					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,553,500	0	0	0	0	30.00
43.00	04300	NURSERY	937,714	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,246,811	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,439,242	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,968,311	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,697,748	0	0	0	0	54.00
60.00	06000	LABORATORY	14,878,000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	5,088,144	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,427,929	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	935,134	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	373,089	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	827,256	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,748,643	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,298,973	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,119,841	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	17,714,949	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	6,443,537	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	144,698,821	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	24,870	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000172	0.000000	0.000000	0.000000	0.000000	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150091

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

Worksheet B-1

Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	3,533	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000024	0.000000	0.000000	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)		
			22.00	23.00		
		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
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
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
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OCC HEALTH	0	0		194.00
194.01	07951	PAIN CLINIC	0	0		194.01
194.02	07952	OCC HEALTH	0	0		194.02
194.03	07953	FOUNDATIO	0	0		194.03
194.04	07954	KIDS CAMPUS	0	0		194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0		194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0		194.06
194.07	07957	MISC CATERING	0	0		194.07
194.08	07958	AUTISM CENTER	0	0		194.08
194.09	07959	HUNTINGTON BUA	0	0		194.09
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 Date/Time Prepared: 10/28/2016 10:35 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	
			22.00	23.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 10/28/2016 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,068,236		7,068,236	0	7,068,236	30.00
43.00	04300	NURSERY	81,750		81,750	0	81,750	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,813,864		1,813,864	1,096	1,814,960	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,329,113		1,329,113	0	1,329,113	52.00
53.00	05300	ANESTHESIOLOGY	1,180,104		1,180,104	0	1,180,104	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,290,039		3,290,039	0	3,290,039	54.00
60.00	06000	LABORATORY	3,045,636		3,045,636	0	3,045,636	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,393,504	0	1,393,504	0	1,393,504	65.00
66.00	06600	PHYSICAL THERAPY	1,795,724	0	1,795,724	0	1,795,724	66.00
67.00	06700	OCCUPATIONAL THERAPY	353,049	0	353,049	0	353,049	67.00
68.00	06800	SPEECH PATHOLOGY	141,812	0	141,812	0	141,812	68.00
69.00	06900	ELECTROCARDIOLOGY	13,891		13,891	0	13,891	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,155,625		1,155,625	0	1,155,625	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,890,092		1,890,092	0	1,890,092	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,814,424		2,814,424	0	2,814,424	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,697,981		2,697,981	0	2,697,981	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,342,501		1,342,501		1,342,501	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,628,157		3,628,157	0	3,628,157	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	35,035,502	0	35,035,502	1,096	35,036,598	200.00
201.00		Less Observation Beds	1,342,501		1,342,501		1,342,501	201.00
202.00		Total (see instructions)	33,693,001	0	33,693,001	1,096	33,694,097	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 10/28/2016 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,209,434		7,209,434			30.00
43.00	04300	NURSERY	937,714		937,714			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,144,868	13,101,943	19,246,811	0.094242	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,439,242	0	3,439,242	0.386455	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	683,420	2,284,891	2,968,311	0.397568	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,248,338	28,449,410	31,697,748	0.103794	0.000000	54.00
60.00	06000	LABORATORY	2,773,384	12,104,616	14,878,000	0.204707	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	1,373,450	3,714,694	5,088,144	0.273873	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	549,561	2,878,368	3,427,929	0.523851	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,274	885,860	935,134	0.377538	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,349	356,740	373,089	0.380102	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	616,184	211,072	827,256	0.016792	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,511,563	7,237,080	9,748,643	0.118542	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,165,632	1,133,341	5,298,973	0.356690	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,680,319	8,439,522	13,119,841	0.214517	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,114,121	15,600,828	17,714,949	0.152300	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,344,066	1,344,066	0.998836	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	6,443,537	6,443,537	0.563069	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	40,512,853	104,185,968	144,698,821			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	40,512,853	104,185,968	144,698,821			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I | Date/Time Prepared: 10/28/2016 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.094299	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.386455	52.00
53.00	05300	ANESTHESIOLOGY	0.397568	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103794	54.00
60.00	06000	LABORATORY	0.204707	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.273873	65.00
66.00	06600	PHYSICAL THERAPY	0.523851	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.377538	67.00
68.00	06800	SPEECH PATHOLOGY	0.380102	68.00
69.00	06900	ELECTROCARDIOLOGY	0.016792	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.118542	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.356690	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214517	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.152300	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.998836	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.563069	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 10/28/2016 10:35 am

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	7,068,236		7,068,236	0	7,068,236	30.00
43.00	04300	NURSERY	81,750		81,750	0	81,750	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,813,864		1,813,864	1,096	1,814,960	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,329,113		1,329,113	0	1,329,113	52.00
53.00	05300	ANESTHESIOLOGY	1,180,104		1,180,104	0	1,180,104	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,290,039		3,290,039	0	3,290,039	54.00
60.00	06000	LABORATORY	3,045,636		3,045,636	0	3,045,636	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,393,504	0	1,393,504	0	1,393,504	65.00
66.00	06600	PHYSICAL THERAPY	1,795,724	0	1,795,724	0	1,795,724	66.00
67.00	06700	OCCUPATIONAL THERAPY	353,049	0	353,049	0	353,049	67.00
68.00	06800	SPEECH PATHOLOGY	141,812	0	141,812	0	141,812	68.00
69.00	06900	ELECTROCARDIOLOGY	13,891		13,891	0	13,891	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,155,625		1,155,625	0	1,155,625	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,890,092		1,890,092	0	1,890,092	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,814,424		2,814,424	0	2,814,424	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,697,981		2,697,981	0	2,697,981	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,342,501		1,342,501		1,342,501	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,628,157		3,628,157	0	3,628,157	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	35,035,502	0	35,035,502	1,096	35,036,598	200.00
201.00		Less Observation Beds	1,342,501		1,342,501		1,342,501	201.00
202.00		Total (see instructions)	33,693,001	0	33,693,001	1,096	33,694,097	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 10/28/2016 10:35 am

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	7,209,434		7,209,434			30.00
43.00	04300	NURSERY	937,714		937,714			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,144,868	13,101,943	19,246,811	0.094242	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,439,242	0	3,439,242	0.386455	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	683,420	2,284,891	2,968,311	0.397568	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,248,338	28,449,410	31,697,748	0.103794	0.000000	54.00
60.00	06000	LABORATORY	2,773,384	12,104,616	14,878,000	0.204707	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	1,373,450	3,714,694	5,088,144	0.273873	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	549,561	2,878,368	3,427,929	0.523851	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,274	885,860	935,134	0.377538	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,349	356,740	373,089	0.380102	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	616,184	211,072	827,256	0.016792	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,511,563	7,237,080	9,748,643	0.118542	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,165,632	1,133,341	5,298,973	0.356690	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,680,319	8,439,522	13,119,841	0.214517	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,114,121	15,600,828	17,714,949	0.152300	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,344,066	1,344,066	0.998836	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	6,443,537	6,443,537	0.563069	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	40,512,853	104,185,968	144,698,821			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	40,512,853	104,185,968	144,698,821			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 150091	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 10/28/2016 10:35 am
	Title XIX	Hospital	PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.094299	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.386455	52.00
53.00	05300	ANESTHESIOLOGY	0.397568	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103794	54.00
60.00	06000	LABORATORY	0.204707	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.273873	65.00
66.00	06600	PHYSICAL THERAPY	0.523851	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.377538	67.00
68.00	06800	SPEECH PATHOLOGY	0.380102	68.00
69.00	06900	ELECTROCARDIOLOGY	0.016792	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.118542	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.356690	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214517	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.152300	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.998836	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.563069	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II | Date/Time Prepared: 10/28/2016 10:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,813,864	149,123	1,664,741	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,329,113	87,584	1,241,529	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,180,104	77,456	1,102,648	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,290,039	473,880	2,816,159	0	0	54.00
60.00	06000	LABORATORY	3,045,636	205,419	2,840,217	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,393,504	135,400	1,258,104	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,795,724	156,125	1,639,599	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	353,049	23,176	329,873	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	141,812	9,309	132,503	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	13,891	922	12,969	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,155,625	79,404	1,076,221	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,890,092	222,401	1,667,691	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,814,424	184,884	2,629,540	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,697,981	234,375	2,463,606	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,342,501	128,962	1,213,539	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,628,157	405,899	3,222,258	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	27,885,516	2,574,319	25,311,197	0	0	200.00
201.00		Less Observation Beds	1,342,501	128,962	1,213,539	0	0	201.00
202.00		Total (line 200 minus line 201)	26,543,015	2,445,357	24,097,658	0	0	202.00

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

Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II | Date/Time Prepared: 10/28/2016 10:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,813,864	19,246,811	0.094242		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,329,113	3,439,242	0.386455		52.00
53.00	05300	ANESTHESIOLOGY	1,180,104	2,968,311	0.397568		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,290,039	31,697,748	0.103794		54.00
60.00	06000	LABORATORY	3,045,636	14,878,000	0.204707		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	1,393,504	5,088,144	0.273873		65.00
66.00	06600	PHYSICAL THERAPY	1,795,724	3,427,929	0.523851		66.00
67.00	06700	OCCUPATIONAL THERAPY	353,049	935,134	0.377538		67.00
68.00	06800	SPEECH PATHOLOGY	141,812	373,089	0.380102		68.00
69.00	06900	ELECTROCARDIOLOGY	13,891	827,256	0.016792		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,155,625	9,748,643	0.118542		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,890,092	5,298,973	0.356690		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,814,424	13,119,841	0.214517		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000		76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	2,697,981	17,714,949	0.152300		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,342,501	1,344,066	0.998836		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	3,628,157	6,443,537	0.563069		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	27,885,516	136,551,673			200.00
201.00		Less Observation Beds	1,342,501	0			201.00
202.00		Total (line 200 minus line 201)	26,543,015	136,551,673			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I | Date/Time Prepared: 10/28/2016 10:35 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	678,982	0	678,982	5,544	122.47	30.00
43.00	NURSERY	5,712		5,712	725	7.88	43.00
200.00	Total (lines 30-199)	684,694		684,694	6,269		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	1,424	174,397	30.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	1,424	174,397	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 10/28/2016 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	149,123	19,246,811	0.007748	1,252,305	9,703	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	87,584	3,439,242	0.025466	0	0	52.00
53.00	05300	ANESTHESIOLOGY	77,456	2,968,311	0.026094	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	473,880	31,697,748	0.014950	1,196,416	17,886	54.00
60.00	06000	LABORATORY	205,419	14,878,000	0.013807	940,991	12,992	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	135,400	5,088,144	0.026611	534,595	14,226	65.00
66.00	06600	PHYSICAL THERAPY	156,125	3,427,929	0.045545	248,955	11,339	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,176	935,134	0.024784	21,360	529	67.00
68.00	06800	SPEECH PATHOLOGY	9,309	373,089	0.024951	9,297	232	68.00
69.00	06900	ELECTROCARDIOLOGY	922	827,256	0.001115	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	79,404	9,748,643	0.008145	442,569	3,605	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	222,401	5,298,973	0.041971	1,414,048	59,349	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	184,884	13,119,841	0.014092	1,368,220	19,281	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	234,375	17,714,949	0.013230	846,276	11,196	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	128,962	1,344,066	0.095949	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,168,420	130,108,136		8,275,032	160,338	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 10/28/2016 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,544	0.00	1,424	0	30.00
43.00	04300	NURSERY	725	0.00	0	0	43.00
200.00		Total (lines 30-199)	6,269		1,424	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 10/28/2016 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 10/28/2016 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	19,246,811	0.000000	0.000000	1,252,305	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,439,242	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,968,311	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,697,748	0.000000	0.000000	1,196,416	54.00
60.00	06000	LABORATORY	0	14,878,000	0.000000	0.000000	940,991	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	5,088,144	0.000000	0.000000	534,595	65.00
66.00	06600	PHYSICAL THERAPY	0	3,427,929	0.000000	0.000000	248,955	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	935,134	0.000000	0.000000	21,360	67.00
68.00	06800	SPEECH PATHOLOGY	0	373,089	0.000000	0.000000	9,297	68.00
69.00	06900	ELECTROCARDIOLOGY	0	827,256	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,748,643	0.000000	0.000000	442,569	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,298,973	0.000000	0.000000	1,414,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,119,841	0.000000	0.000000	1,368,220	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	17,714,949	0.000000	0.000000	846,276	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,344,066	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	130,108,136			8,275,032	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 10/28/2016 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,078,535	0	50.00
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	6,483,709	0	54.00
60.00	06000	LABORATORY	0	432,136	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	645,229	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	358,924	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	147,738	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,737,347	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	2,937,146	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	613,520	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	16,434,284	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 10/28/2016 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.094242	3,078,535	0	0	290,127	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.386455	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.397568	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103794	6,483,709	0	0	672,970	54.00
60.00	06000	LABORATORY	0.204707	432,136	0	0	88,461	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.273873	645,229	0	0	176,711	65.00
66.00	06600	PHYSICAL THERAPY	0.523851	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.377538	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.380102	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.016792	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.118542	358,924	0	0	42,548	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.356690	147,738	0	0	52,697	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214517	1,737,347	0	0	372,690	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.152300	2,937,146	0	0	447,327	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.998836	613,520	0	0	612,806	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.563069		0			95.00
200.00		Subtotal (see instructions)		16,434,284	0	0	2,756,337	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		16,434,284	0	0	2,756,337	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 10/28/2016 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
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
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
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
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I Date/Time Prepared: 10/28/2016 10:35 am

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	678,982	0	678,982	5,544	122.47	30.00
43.00	NURSERY	5,712		5,712	725	7.88	43.00
200.00	Total (lines 30-199)	684,694		684,694	6,269		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	176	21,555	30.00
43.00	NURSERY	71	559	43.00
200.00	Total (lines 30-199)	247	22,114	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 10/28/2016 10:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	149,123	19,246,811	0.007748	2,630,932	20,384	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	87,584	3,439,242	0.025466	0	0	52.00
53.00	05300	ANESTHESIOLOGY	77,456	2,968,311	0.026094	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	473,880	31,697,748	0.014950	370,959	5,546	54.00
60.00	06000	LABORATORY	205,419	14,878,000	0.013807	495,508	6,841	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	135,400	5,088,144	0.026611	261,425	6,957	65.00
66.00	06600	PHYSICAL THERAPY	156,125	3,427,929	0.045545	20,555	936	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,176	935,134	0.024784	2,461	61	67.00
68.00	06800	SPEECH PATHOLOGY	9,309	373,089	0.024951	357	9	68.00
69.00	06900	ELECTROCARDIOLOGY	922	827,256	0.001115	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	79,404	9,748,643	0.008145	216,501	1,763	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	222,401	5,298,973	0.041971	137,471	5,770	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	184,884	13,119,841	0.014092	904,803	12,750	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	234,375	17,714,949	0.013230	256,645	3,395	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	128,962	1,344,066	0.095949	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,168,420	130,108,136		5,297,617	64,412	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 10/28/2016 10:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,544	0.00	176	0	30.00
43.00	04300	NURSERY	725	0.00	71	0	43.00
200.00		Total (lines 30-199)	6,269		247	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 10/28/2016 10:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150091	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 10/28/2016 10:35 am
	Title XIX	Hospital	PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	19,246,811	0.000000	0.000000	2,630,932	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,439,242	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,968,311	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,697,748	0.000000	0.000000	370,959	54.00
60.00	06000	LABORATORY	0	14,878,000	0.000000	0.000000	495,508	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	5,088,144	0.000000	0.000000	261,425	65.00
66.00	06600	PHYSICAL THERAPY	0	3,427,929	0.000000	0.000000	20,555	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	935,134	0.000000	0.000000	2,461	67.00
68.00	06800	SPEECH PATHOLOGY	0	373,089	0.000000	0.000000	357	68.00
69.00	06900	ELECTROCARDIOLOGY	0	827,256	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,748,643	0.000000	0.000000	216,501	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,298,973	0.000000	0.000000	137,471	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,119,841	0.000000	0.000000	904,803	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	17,714,949	0.000000	0.000000	256,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,344,066	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	130,108,136			5,297,617	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 10/28/2016 10:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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
60.00	06000	LABORATORY	0	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
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
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 10/28/2016 10:35 am

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	0.094242	0	4,364,943	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.386455	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.397568	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103794	0	4,890,323	0	0	54.00
60.00	06000	LABORATORY	0.204707	0	2,241,992	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.273873	0	375,359	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.523851	0	525,549	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.377538	0	295,548	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.380102	0	177,446	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.016792	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.118542	0	316,404	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.356690	0	179,861	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214517	0	995,068	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.152300	0	4,455,817	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.998836	0	274,720	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.563069	0	844,030			95.00
200.00		Subtotal (see instructions)		0	19,937,060	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	19,937,060	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 10/28/2016 10:35 am

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	411,361	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	507,586	0	54.00
60.00	06000	LABORATORY	458,951	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	102,801	0	65.00
66.00	06600	PHYSICAL THERAPY	275,309	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	111,581	0	67.00
68.00	06800	SPEECH PATHOLOGY	67,448	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,507	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,155	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	213,459	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	678,621	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	274,400	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	475,247		95.00
200.00		Subtotal (see instructions)	3,678,426	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	3,678,426	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 10/28/2016 10:35 am

Title XVIII | Hospital | PPS

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,544	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,544	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)	4,491	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)	1,424	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,068,236	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,068,236	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,068,236	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,274.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,815,500	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)	1,815,500	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 Date/Time Prepared: 10/28/2016 10:35 am

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						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,702,557	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,518,057	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)	174,397	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	160,338	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	334,735	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,183,322	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,053	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,274.93	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,342,501	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150091	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 10/28/2016 10:35 am
	Title XVIII	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	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	678,982	7,068,236	0.096061	1,342,501	128,962	90.00
91.00	Nursing School cost	0	7,068,236	0.000000	1,342,501	0	91.00
92.00	Allied health cost	0	7,068,236	0.000000	1,342,501	0	92.00
93.00	All other Medical Education	0	7,068,236	0.000000	1,342,501	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 Date/Time Prepared: 10/28/2016 10:35 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,544	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,544	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)	4,491	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)	176	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)	725	15.00
16.00	Nursery days (title V or XIX only)	71	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,068,236	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,068,236	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,068,236	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,274.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	224,388	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)	224,388	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 10/28/2016 10:35 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	81,750	725	112.76	71	8,006	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	779,343	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,011,737	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)	22,114	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	64,412	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	86,526	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	925,211	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,053	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,274.93	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,342,501	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150091	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 10/28/2016 10:35 am
	Title XIX	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	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	678,982	7,068,236	0.096061	1,342,501	128,962	90.00
91.00	Nursing School cost	0	7,068,236	0.000000	1,342,501	0	91.00
92.00	Allied health cost	0	7,068,236	0.000000	1,342,501	0	92.00
93.00	All other Medical Education	0	7,068,236	0.000000	1,342,501	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 10/28/2016 10:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,682,916		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.094299	1,252,305	118,091	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.386455	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.397568	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103794	1,196,416	124,181	54.00
60.00	06000	LABORATORY	0.204707	940,991	192,627	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.273873	534,595	146,411	65.00
66.00	06600	PHYSICAL THERAPY	0.523851	248,955	130,415	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.377538	21,360	8,064	67.00
68.00	06800	SPEECH PATHOLOGY	0.380102	9,297	3,534	68.00
69.00	06900	ELECTROCARDIOLOGY	0.016792	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.118542	442,569	52,463	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.356690	1,414,048	504,377	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214517	1,368,220	293,506	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.152300	846,276	128,888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.998836	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		8,275,032	1,702,557	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		8,275,032		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 10/28/2016 10:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,336,343		30.00
43.00	04300	NURSERY		488,441		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.094299	2,630,932	248,094	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.386455	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.397568	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103794	370,959	38,503	54.00
60.00	06000	LABORATORY	0.204707	495,508	101,434	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.273873	261,425	71,597	65.00
66.00	06600	PHYSICAL THERAPY	0.523851	20,555	10,768	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.377538	2,461	929	67.00
68.00	06800	SPEECH PATHOLOGY	0.380102	357	136	68.00
69.00	06900	ELECTROCARDIOLOGY	0.016792	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.118542	216,501	25,664	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.356690	137,471	49,035	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214517	904,803	194,096	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.152300	256,645	39,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.998836	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		5,297,617	779,343	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)		5,297,617		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150091	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 10/28/2016 10:35 am
	Title XVIII	Hospital	PPS

		1.00	
	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)	1,961,068	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	676,133	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)	2,055	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	33.12	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)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.51	30.00
31.00	Percentage of Medicaid patient days (see instructions)	29.13	31.00
32.00	Sum of lines 30 and 31	32.64	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	79,116	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150091	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 10/28/2016 10:35 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000051392	0.000051203	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	393,028	328,014	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	293,963	82,452	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	376,415		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 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	3,094,787		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	3,094,787	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	209,835	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	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)	3,304,622	59.00
60.00	Primary payer payments	4,110	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	3,300,512	61.00
62.00	Deductibles billed to program beneficiaries	422,946	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	30,329	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	19,714	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	22,934	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	2,897,280	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
70.88	SCH or MDH volume decrease adjustment	0	70.88
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)	23,901	70.93
70.94	HRR adjustment amount (see instructions)	-7,216	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150091	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 10/28/2016 10:35 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2015	279,522	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)	2016	106,545	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)		3,300,032	71.00
71.01	Sequestration adjustment (see instructions)		66,001	71.01
72.00	Interim payments		3,147,241	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)		86,790	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		210,220	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

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0016715778	1.0084637595	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9967	0.9989	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 10/28/2016 10:35 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,961,068	0	1,961,068		1,961,068	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	676,133	0		676,133	676,133	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	2,055	0	77	1,978	2,055	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	79,116	0	58,832	20,284	79,116	11.00
11.01	Uncompensated care payments	36.00	376,415	0	293,963	82,452	376,415	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,094,787	0	2,313,940	780,847	3,094,787	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,094,787	0	2,313,940	780,847	3,094,787	15.00
16.00	Payment for inpatient program capital	50.00	209,835	0	155,034	54,801	209,835	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 10/28/2016 10:35 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	2,468,974	835,648	3,304,622	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	209,835	0	155,034	54,801	209,835	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	209,835	0	155,034	54,801	209,835	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.113214	0.127500		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			279,522		279,522	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				106,545	106,545	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150091	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 10/28/2016 10:35 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,756,337	2.00
3.00	PPS payments	2,529,927	3.00
4.00	Outlier payment (see instructions)	9,617	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.859	5.00
6.00	Line 2 times line 5	2,367,693	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	2,539,544	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	581,539	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,958,005	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,958,005	30.00
31.00	Primary payer payments	1,277	31.00
32.00	Subtotal (line 30 minus line 31)	1,956,728	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)	75,210	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	48,887	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	68,647	36.00
37.00	Subtotal (see instructions)	2,005,615	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,005,615	40.00
40.01	Sequestration adjustment (see instructions)	40,112	40.01
41.00	Interim payments	1,917,597	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	47,906	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: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I Date/Time Prepared: 10/28/2016 10:35 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,147,241		1,917,597	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,147,241		1,917,597	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		86,790		47,906	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,234,031		1,965,503	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150091	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 10/28/2016 10:35 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,607	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,424	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,148	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4,491	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	144,698,821	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,705,594	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)	305,165	8.00
9.00	Sequestration adjustment amount (see instructions)	6,103	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	299,062	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	274,921	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)	24,141	32.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 10/28/2016 10:35 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,550	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	16,324,146	0	0	0	4.00
5.00	Other receivable	218,561	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,472,035	0	0	0	6.00
7.00	Inventory	208,223	0	0	0	7.00
8.00	Prepaid expenses	1,391,349	0	0	0	8.00
9.00	Other current assets	0	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)	7,672,794	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	465,871	0	0	0	13.00
14.00	Accumulated depreciation	-259,799	0	0	0	14.00
15.00	Buildings	1,927,095	0	0	0	15.00
16.00	Accumulated depreciation	-999,486	0	0	0	16.00
17.00	Leasehold improvements	32,500	0	0	0	17.00
18.00	Accumulated depreciation	-28,437	0	0	0	18.00
19.00	Fixed equipment	510,214	0	0	0	19.00
20.00	Accumulated depreciation	-491,323	0	0	0	20.00
21.00	Automobiles and trucks	660,453	0	0	0	21.00
22.00	Accumulated depreciation	-579,972	0	0	0	22.00
23.00	Major movable equipment	9,707,084	0	0	0	23.00
24.00	Accumulated depreciation	-8,180,105	0	0	0	24.00
25.00	Minor equipment depreciable	1,175,184	0	0	0	25.00
26.00	Accumulated depreciation	-778,677	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	156,783	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	3,317,385	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	31,421,235	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	33,799	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	31,455,034	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	42,445,213	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	740,985	0	0	0	37.00
38.00	Salaries, wages, and fees payable	713,193	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	69,828	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	201,641	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,725,647	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	36,175	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	33,797	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	69,972	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	1,795,619	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	40,649,594				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)	40,649,594	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	42,445,213	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 10/28/2016 10:35 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		40,578,818		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		12,570,308				2.00
3.00	Total (sum of line 1 and line 2)		53,149,126		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)		53,149,126		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ASSET TRANSFERS	12,499,532		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)		12,499,532		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		40,649,594		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	ASSET TRANSFERS		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: 150091 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 10/28/2016 10:35 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,410,010		7,410,010	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,410,010		7,410,010	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,410,010		7,410,010	17.00
18.00	Ancillary services	33,850,556	0	33,850,556	18.00
19.00	Outpatient services	0	103,495,080	103,495,080	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	6,473,588	6,473,588	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)	41,260,566	109,968,668	151,229,234	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		41,347,028		29.00
30.00	PROVISION FOR BAD DEBT	7,340,468			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)		7,340,468		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)		48,687,496		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150091	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prepared: 10/28/2016 10:35 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	151,229,234	1.00
2.00	Less contractual allowances and discounts on patients' accounts	90,952,095	2.00
3.00	Net patient revenues (line 1 minus line 2)	60,277,139	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	48,687,496	4.00
5.00	Net income from service to patients (line 3 minus line 4)	11,589,643	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-1,159,298	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	152,379	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)	0	24.00
24.01	GAIN/LOSS ON SALE OF CAPITAL ASSETS	0	24.01
24.02	EMS SUBSIDY	250,000	24.02
24.03	OTHER REVENUE	1,737,584	24.03
25.00	Total other income (sum of lines 6-24)	980,665	25.00
26.00	Total (line 5 plus line 25)	12,570,308	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)	12,570,308	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150091	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 10/28/2016 10:35 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	209,835	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	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)	12.83	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	209,835	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