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: 150102	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/26/2016 9:15 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/26/2016 Time: 9:15 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 IU HEALTH STARKE MEMORIAL HOSPITAL (150102) 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 Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-1,980	90,501	-58,996	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	-1,980	90,501	-58,996	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2016 9:14 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 102 EAST CULVER RD	PO Box:			1.00
2.00	City: KNOX	State: IN	Zip Code: 46534	County: STARKE	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	IU HEALTH STARKE MEMORIAL HOSPITAL	150102	23844	1	07/11/1966	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	IU HEALTH STARKE MEMORIAL SWING BED	15U102	23844		09/06/1989	N	P	N	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: 1.00	To: 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 §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	76	5	0	0	208	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: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 9:14 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	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.	1		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	01/01/2015	12/31/2015	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.				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.				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
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2016 9:14 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 9:14 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.		Y	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)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	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	N	N	N	109.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	33,870	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	Y	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

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		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	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: INDIANA UNIVERSITY HEALTH INC	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box: N/A		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	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

		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)	10/01/2014	09/30/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150102	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 9:14 am

			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2016 9:14 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	04/05/2016	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2016 9:14 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
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				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	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.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	IU HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.962.1093	RUTTER@IUHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2016 9:14 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/05/2016			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.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGE, REVENUE & 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: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2016 9:14 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	50	18,250	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)		50	18,250	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		50	18,250	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)		50				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: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2016 9:14 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)	936	289	1,648			1.00
2.00	HMO and other (see instructions)	111	0				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)	936	289	1,648			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	936	289	1,648	0.00	122.14	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	122.14	27.00
28.00	Observation Bed Days		14	1,019			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			7			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2016 9:14 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	296	20	498	1.00
2.00	HMO and other (see instructions)			35	68		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	296	20	498	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: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/26/2016 9:14 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	6,728,788	-17,225	6,711,563	254,050.76	26.42	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		18,330	0	18,330	107.04	171.24	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		80,902	0	80,902	4,568.46	17.71	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		407,788	0	407,788	2,380.12	171.33	13.00
14.00	Home office salaries & wage-related costs		464,656	0	464,656	8,135.00	57.12	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)		1,673,118	0	1,673,118			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		26,928	0	26,928			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		2,103	0	2,103			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	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	856,899	-2,747	854,152	34,023.11	25.11	27.00
28.00	Administrative & General under contract (see inst.)		70,463	0	70,463	1,289.00	54.66	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	374,953	-200	374,753	17,809.47	21.04	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	187,102	-1,199	185,903	13,297.57	13.98	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	185,284	-134,274	51,010	3,015.87	16.91	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	133,534	133,534	7,947.22	16.80	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	32,407	0	32,407	2,253.08	14.38	38.00
39.00	Central Services and Supply	14.00	77,775	0	77,775	4,160.37	18.69	39.00
40.00	Pharmacy	15.00	195,227	0	195,227	5,293.82	36.88	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/26/2016 9:14 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
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: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part III Date/Time Prepared: 5/26/2016 9:14 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		6,799,251	-17,225	6,782,026	255,339.76	26.56	1.00
2.00	Excluded area salaries (see instructions)		80,902	0	80,902	4,568.46	17.71	2.00
3.00	Subtotal salaries (line 1 minus line 2)		6,718,349	-17,225	6,701,124	250,771.30	26.72	3.00
4.00	Subtotal other wages & related costs (see inst.)		872,444	0	872,444	10,515.12	82.97	4.00
5.00	Subtotal wage-related costs (see inst.)		1,675,221	0	1,675,221	0.00	25.00	5.00
6.00	Total (sum of lines 3 thru 5)		9,266,014	-17,225	9,248,789	261,286.42	35.40	6.00
7.00	Total overhead cost (see instructions)		1,980,110	-4,886	1,975,224	89,089.51	22.17	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 5/26/2016 9:14 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	100,191	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	993,790	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)	7,639	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)	48,671	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	22,986	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	492,492	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	8,072	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))	17,762	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	10,546	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,702,149	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: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part V Date/Time Prepared: 5/26/2016 9:14 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			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: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-10 | Date/Time Prepared: 5/26/2016 9:14 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)	0.266400	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,057,405	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?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	20,732,967	6.00
7.00	Medicaid cost (line 1 times line 6)	5,523,262	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)	1,465,857	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	803,470	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	8,936,824	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	2,380,770	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)	1,577,300	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	18,736	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)	3,043,157	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	1,395,488	781,388	2,176,876	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	371,758	208,162	579,920	21.00
22.00	Partial payment by patients approved for charity care	7,649	35,838	43,487	22.00
23.00	Cost of charity care (line 21 minus line 22)	364,109	172,324	536,433	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)	2,025,759	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	96,800	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,928,959	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	513,875	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,050,308	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,093,465	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/26/2016 9:14 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	171,414	171,414	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,137,073	1,137,073	0	1,137,073	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	856,899	3,195,518	4,052,417	-172,101	3,880,316	5.00
7.00	00700	OPERATION OF PLANT	374,953	751,894	1,126,847	-8,508	1,118,339	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	187,102	99,663	286,765	0	286,765	9.00
10.00	01000	DIETARY	185,284	113,826	299,110	-215,572	83,538	10.00
11.00	01100	CAFETERIA	0	0	0	215,557	215,557	11.00
13.00	01300	NURSING ADMINISTRATION	32,407	19,860	52,267	0	52,267	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	77,775	34,762	112,537	-2,141	110,396	14.00
15.00	01500	PHARMACY	195,227	720,728	915,955	-640,516	275,439	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	345,350	345,350	0	345,350	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,091,569	200,567	1,292,136	-1,664	1,290,472	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	625,521	735,047	1,360,568	-173,410	1,187,158	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	290,772	290,772	0	290,772	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,015,750	1,320,882	2,336,632	-24,945	2,311,687	54.00
57.00	05700	CT SCAN	2,718	271,476	274,194	0	274,194	57.00
58.00	05800	MRI	82,074	159,949	242,023	0	242,023	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	431,691	740,328	1,172,019	-1,371	1,170,648	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	36,059	36,059	0	36,059	62.00
65.00	06500	RESPIRATORY THERAPY	261,611	45,600	307,211	-283	306,928	65.00
66.00	06600	PHYSICAL THERAPY	65,491	63,240	128,731	-63	128,668	66.00
67.00	06700	OCCUPATIONAL THERAPY	122,643	28,828	151,471	0	151,471	67.00
68.00	06800	SPEECH PATHOLOGY	11,667	1,177	12,844	0	12,844	68.00
69.00	06900	ELECTROCARDIOLOGY	79,443	41,139	120,582	0	120,582	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	125,262	125,262	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	79,225	79,225	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	665,981	665,981	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	948,061	2,526,882	3,474,943	-663	3,474,280	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,647,886	12,880,620	19,528,506	16,202	19,544,708	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	51,318	24,273	75,591	0	75,591	193.01
193.02	19302	RETAIL PHARMACY	0	23,252	23,252	0	23,252	193.02
194.00	07950	OTHER NRCC	29,584	93,787	123,371	-16,202	107,169	194.00
200.00		TOTAL (SUM OF LINES 118-199)	6,728,788	13,021,932	19,750,720	0	19,750,720	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/26/2016 9:14 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	72,794	244,208		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	28,419	28,419		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	54,168	1,191,241		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,677,723	8,558,039		5.00
7.00	00700	OPERATION OF PLANT	0	1,118,339		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	0	286,765		9.00
10.00	01000	DIETARY	0	83,538		10.00
11.00	01100	CAFETERIA	-73,380	142,177		11.00
13.00	01300	NURSING ADMINISTRATION	-1,028	51,239		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	110,396		14.00
15.00	01500	PHARMACY	0	275,439		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	345,350		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-9,354	1,281,118		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,631	1,185,527		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	-280,842	9,930		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-9,412	2,302,275		54.00
57.00	05700	CT SCAN	-327	273,867		57.00
58.00	05800	MRI	-339	241,684		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-1,794	1,168,854		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	36,059		62.00
65.00	06500	RESPIRATORY THERAPY	-470	306,458		65.00
66.00	06600	PHYSICAL THERAPY	-217	128,451		66.00
67.00	06700	OCCUPATIONAL THERAPY	-210	151,261		67.00
68.00	06800	SPEECH PATHOLOGY	-42	12,802		68.00
69.00	06900	ELECTROCARDIOLOGY	-891	119,691		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	-11,143	114,119		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	-101	79,124		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-5,390	660,591		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-1,904,643	1,569,637		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,531,890	22,076,598		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0		190.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	WELLNESS CENTER	0	75,591		193.01
193.02	19302	RETAIL PHARMACY	0	23,252		193.02
194.00	07950	OTHER NRCC	0	107,169		194.00
200.00		TOTAL (SUM OF LINES 118-199)	2,531,890	22,282,610		200.00

RECLASSIFICATIONS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/26/2016 9:14 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RENT				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	33,736	1.00
	0		0	33,736	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	133,534	80,452	1.00
2.00	CAFETERIA	11.00	0	1,571	2.00
	0		133,534	82,023	
	C - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	665,981	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	0		0	665,981	
	E - BILLABLE MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	125,262	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	79,225	2.00
3.00		0.00	0	0	3.00
	0		0	204,487	
	H - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,625	1.00
	0		0	3,625	
	I - PTO USED AS SHORT-TERM DIABILITY				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,747	1.00
2.00	OPERATION OF PLANT	7.00	0	200	2.00
3.00	HOUSEKEEPING	9.00	0	1,199	3.00
4.00	DIETARY	10.00	0	740	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	3,796	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,557	6.00
7.00	LABORATORY	60.00	0	3,132	7.00
8.00	EMERGENCY	91.00	0	2,854	8.00
	0		0	17,225	
	J - UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	28,863	1.00
2.00		0.00	0	0	2.00
	0		0	28,863	
	K - PROPERTY TAXES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	134,053	1.00
2.00		0.00	0	0	2.00
	0		0	134,053	
500.00	Grand Total: Increases		133,534	1,169,993	500.00

RECLASSIFICATIONS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/26/2016 9:14 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	33,736	10		1.00
	0		0	33,736			
	B - CAFETERIA						
1.00	DIETARY	10.00	133,534	80,452	0		1.00
2.00	DIETARY	10.00	0	1,571	9		2.00
	0		133,534	82,023			
	C - DRUGS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,404	0		1.00
2.00	DIETARY	10.00	0	15	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,881	0		3.00
4.00	PHARMACY	15.00	0	640,516	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	1,664	0		5.00
6.00	OPERATING ROOM	50.00	0	6,554	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,284	0		7.00
8.00	LABORATORY	60.00	0	654	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	283	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	63	0		10.00
11.00	EMERGENCY	91.00	0	663	0		11.00
	0		0	665,981			
	E - BILLABLE MEDICAL SUPPLIES						
1.00	OPERATION OF PLANT	7.00	0	37,371	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	260	0		2.00
3.00	OPERATING ROOM	50.00	0	166,856	0		3.00
	0		0	204,487			
	H - INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,625	11		1.00
	0		0	3,625			
	I - PTO USED AS SHORT-TERM DIABILITY						
1.00	ADMINISTRATIVE & GENERAL	5.00	2,747	0	0		1.00
2.00	OPERATION OF PLANT	7.00	200	0	0		2.00
3.00	HOUSEKEEPING	9.00	1,199	0	0		3.00
4.00	DIETARY	10.00	740	0	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	3,796	0	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	2,557	0	0		6.00
7.00	LABORATORY	60.00	3,132	0	0		7.00
8.00	EMERGENCY	91.00	2,854	0	0		8.00
	0		17,225	0			
	J - UTILITIES						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,661	0		1.00
2.00	OTHER NRCC	194.00	0	16,202	0		2.00
	0		0	28,863			
	K - PROPERTY TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	133,336	13		1.00
2.00	LABORATORY	60.00	0	717	0		2.00
	0		0	134,053			
500.00	Grand Total: Decreases		150,759	1,152,768			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2016 9:14 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	142,789	0	0	0	0	1.00
2.00	Land Improvements	4,448	33,000	0	33,000	0	2.00
3.00	Buildings and Fixtures	1,509,571	0	0	0	0	3.00
4.00	Building Improvements	5,009,780	130,035	0	130,035	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	9,135,673	617,304	0	617,304	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,802,261	780,339	0	780,339	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	15,802,261	780,339	0	780,339	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	142,789	0	1.00
2.00	Land Improvements	37,448	0	2.00
3.00	Buildings and Fixtures	1,509,571	0	3.00
4.00	Building Improvements	5,139,815	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	9,752,977	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,582,600	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	16,582,600	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II Date/Time Prepared: 5/26/2016 9:14 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2016 9:14 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,689,808	0	1,689,808	0.101902	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,892,792	0	14,892,792	0.898098	0	2.00
3.00	Total (sum of lines 1-2)	16,582,600	0	16,582,600	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	75,870	33,736	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	28,419	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	104,289	33,736	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	549	0	134,053	0	244,208	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	28,419	2.00
3.00	Total (sum of lines 1-2)	549	0	134,053	0	272,627	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/26/2016 9:14 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-3,076	CAP REL COSTS-BLDG & FIXT	1.00	11	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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,218,159			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	5,512,856			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-73,380	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	B	-10,727	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-4,291	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	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	MEDICAID ASSESSMENT FEE	A	-305,362	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	MISCELLANEOUS INCOME	B	-1,434	ADMINISTRATIVE & GENERAL	5.00	0	34.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/26/2016 9:14 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
35.00	MISCELLANEOUS INCOME	B	-1,028	NURSING ADMINISTRATION	13.00	0	35.00
36.00	MARKETING	A	-30,716	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	PATIENT PHONES	A	-7,911	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	ADMISSIONS TIME FOR PATIENT PHONES	A	-36,819	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	EMPLOYEE BENEFITS	A	-267,010	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
40.00	PUBLIC RELATIONS - MARKETING	A	317	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	SELF-INSURANCE OFFSET	A	-9,354	ADULTS & PEDIATRICS	30.00	0	41.00
41.01	SELF-INSURANCE OFFSET	A	-1,631	OPERATING ROOM	50.00	0	41.01
41.02	SELF-INSURANCE OFFSET	A	-20	ANESTHESIOLOGY	53.00	0	41.02
41.03	SELF-INSURANCE OFFSET	A	-2,968	RADIOLOGY-DIAGNOSTIC	54.00	0	41.03
41.04	SELF-INSURANCE OFFSET	A	-327	CT SCAN	57.00	0	41.04
41.05	SELF-INSURANCE OFFSET	A	-339	MRI	58.00	0	41.05
41.06	SELF-INSURANCE OFFSET	A	-1,794	LABORATORY	60.00	0	41.06
41.07	SELF-INSURANCE OFFSET	A	-470	RESPIRATORY THERAPY	65.00	0	41.07
41.08	SELF-INSURANCE OFFSET	A	-217	PHYSICAL THERAPY	66.00	0	41.08
41.09	SELF-INSURANCE OFFSET	A	-210	OCCUPATIONAL THERAPY	67.00	0	41.09
41.10	SELF-INSURANCE OFFSET	A	-42	SPEECH PATHOLOGY	68.00	0	41.10
41.11	SELF-INSURANCE OFFSET	A	-191	ELECTROCARDIOLOGY	69.00	0	41.11
41.12	SELF-INSURANCE OFFSET	A	-416	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	41.12
41.13	SELF-INSURANCE OFFSET	A	-101	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	41.13
41.14	SELF-INSURANCE OFFSET	A	-1,099	DRUGS CHARGED TO PATIENTS	73.00	0	41.14
41.15	SELF-INSURANCE OFFSET	A	-2,191	EMERGENCY	91.00	0	41.15
42.00			0		0.00	0	42.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,531,890				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: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2016 9:14 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	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE CAPITAL BLDG	75,870	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE CAPITAL MME	28,419	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ADMIN	1,017,754	876,957	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	INTERCOMPANY EXPENSE BENEFIT	1,459,442	1,138,264	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY EXPENSE ADMIN	4,946,592	0	4.01
4.02	15.00	PHARMACY	INTERCOMPANY PURCHASED SERVI	51,065	51,065	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	INTERCOMPANY PURCHASED SERVI	345,120	345,120	4.03
4.04	60.00	LABORATORY	INTERCOMPANY PURCHASED SERVI	205,476	205,476	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,129,738	2,616,882	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.

6.00	B		0.00	IU HEALTH INC	100.00	6.00
7.00	B		0.00	LAPORTE REGIONA	100.00	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: 150102	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-1 Date/Time Prepared: 5/26/2016 9:14 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	75,870	9		1.00
2.00	28,419	9		2.00
3.00	140,797	0		3.00
4.00	321,178	0		4.00
4.01	4,946,592	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
5.00	5,512,856			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	HEALTH SYSTEM		6.00
7.00	HEALTH SYSTEM		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: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2016 9:14 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	27,741	27,741	0	211,500	0	1.00
2.00	53.00	ANESTHESIOLOGY	280,822	280,822	0	239,400	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	6,444	6,444	0	271,900	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	700	700	0	211,500	0	4.00
5.00	91.00	EMERGENCY	2,142,728	1,734,940	407,788	211,500	2,363	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			2,458,435	2,050,647	407,788		2,363	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	240,276	12,014	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			240,276	12,014	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	27,741		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	280,822		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	6,444		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	700		4.00
5.00	91.00	EMERGENCY	0	240,276	167,512	1,902,452		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	240,276	167,512	2,218,159		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/26/2016 9:14 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	244,208	244,208				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	28,419		28,419			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,191,241	790	92	1,192,123		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,558,039	25,409	2,957	146,368	8,732,773	5.00
7.00	00700	OPERATION OF PLANT	1,118,339	78,525	9,139	66,907	1,272,910	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	995	116	0	1,111	8.00
9.00	00900	HOUSEKEEPING	286,765	949	110	33,190	321,014	9.00
10.00	01000	DIETARY	83,538	1,868	217	9,107	94,730	10.00
11.00	01100	CAFETERIA	142,177	4,818	561	23,840	171,396	11.00
13.00	01300	NURSING ADMINISTRATION	51,239	210	24	5,786	57,259	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	110,396	3,887	452	13,886	128,621	14.00
15.00	01500	PHARMACY	275,439	1,537	179	34,855	312,010	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	345,350	3,307	385	0	349,042	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,281,118	25,386	2,954	194,208	1,503,666	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,185,527	18,768	2,184	111,677	1,318,156	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	9,930	0	0	0	9,930	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,302,275	12,110	1,409	180,890	2,496,684	54.00
57.00	05700	CT SCAN	273,867	1,064	124	485	275,540	57.00
58.00	05800	MRI	241,684	992	115	14,653	257,444	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,168,854	5,582	650	76,513	1,251,599	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	36,059	0	0	0	36,059	62.00
65.00	06500	RESPIRATORY THERAPY	306,458	6,254	728	46,707	360,147	65.00
66.00	06600	PHYSICAL THERAPY	128,451	4,446	517	11,692	145,106	66.00
67.00	06700	OCCUPATIONAL THERAPY	151,261	640	74	21,896	173,871	67.00
68.00	06800	SPEECH PATHOLOGY	12,802	640	74	2,083	15,599	68.00
69.00	06900	ELECTROCARDIOLOGY	119,691	1,234	144	14,183	135,252	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	114,119	0	0	0	114,119	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,124	0	0	0	79,124	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	660,591	0	0	0	660,591	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,569,637	7,774	905	168,753	1,747,069	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,076,598	207,185	24,110	1,177,679	22,020,822	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	617	72	0	689	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	75,591	0	0	9,162	84,753	193.01
193.02	19302	RETAIL PHARMACY	23,252	0	0	0	23,252	193.02
194.00	07950	OTHER NRCC	107,169	36,406	4,237	5,282	153,094	194.00
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)	22,282,610	244,208	28,419	1,192,123	22,282,610	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/26/2016 9:14 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	8,732,773					5.00
7.00	00700	OPERATION OF PLANT	820,382	2,093,292				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	716	14,929	16,756			8.00
9.00	00900	HOUSEKEEPING	206,891	14,237	0	542,142		9.00
10.00	01000	DIETARY	61,053	28,040	0	9,952	193,775	10.00
11.00	01100	CAFETERIA	110,464	72,308	0	25,663	0	11.00
13.00	01300	NURSING ADMINISTRATION	36,903	3,159	0	1,121	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	82,895	58,331	0	20,702	0	14.00
15.00	01500	PHARMACY	201,088	23,064	0	8,186	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	224,955	49,633	0	17,615	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	969,102	380,968	16,756	135,210	193,775	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	849,542	281,659	0	99,963	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	6,400	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,609,092	181,743	0	64,502	0	54.00
57.00	05700	CT SCAN	177,584	15,967	0	5,667	0	57.00
58.00	05800	MRI	165,921	14,886	0	5,283	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	806,647	83,775	0	29,732	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	23,240	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	232,112	93,857	0	33,311	0	65.00
66.00	06600	PHYSICAL THERAPY	93,520	66,726	0	23,682	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	112,059	9,606	0	3,409	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,053	9,606	0	3,409	0	68.00
69.00	06900	ELECTROCARDIOLOGY	87,169	18,520	0	6,573	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	73,549	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	50,995	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	425,746	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,125,974	116,662	0	41,404	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,564,052	1,537,676	16,756	535,384	193,775	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	444	9,260	0	3,287	0	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	54,623	0	0	0	0	193.01
193.02	19302	RETAIL PHARMACY	14,986	0	0	0	0	193.02
194.00	07950	OTHER NRCC	98,668	546,356	0	3,471	0	194.00
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)	8,732,773	2,093,292	16,756	542,142	193,775	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/26/2016 9:14 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		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
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	379,831					11.00
13.00	01300	NURSING ADMINISTRATION	4,794	103,236				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,878	0	299,427			14.00
15.00	01500	PHARMACY	11,319	0	187	555,854		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	641,245	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83,095	43,506	24,006	0	40,279	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,589	20,759	124,261	0	63,613	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	2,475	0	16,185	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,201	0	16,856	0	70,850	54.00
57.00	05700	CT SCAN	0	0	273	0	69,797	57.00
58.00	05800	MRI	4,306	0	137	0	22,972	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	36,221	0	5,072	0	96,268	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	1,707	62.00
65.00	06500	RESPIRATORY THERAPY	20,951	0	4,198	0	8,162	65.00
66.00	06600	PHYSICAL THERAPY	6,481	0	540	0	7,839	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,303	0	416	0	2,905	67.00
68.00	06800	SPEECH PATHOLOGY	710	0	146	0	1,436	68.00
69.00	06900	ELECTROCARDIOLOGY	5,149	0	653	0	21,628	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	76,430	0	4,472	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,748	0	2,829	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	555,854	68,632	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	69,068	38,971	40,939	0	141,671	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	370,065	103,236	299,337	555,854	641,245	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	4,661	0	0	0	0	193.01
193.02	19302	RETAIL PHARMACY	0	0	5	0	0	193.02
194.00	07950	OTHER NRCC	5,105	0	85	0	0	194.00
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)	379,831	103,236	299,427	555,854	641,245	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/26/2016 9:14 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,390,363	0	3,390,363		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,801,542	0	2,801,542		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	34,990	0	34,990		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,508,928	0	4,508,928		54.00
57.00	05700	CT SCAN	544,828	0	544,828		57.00
58.00	05800	MRI	470,949	0	470,949		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	2,309,314	0	2,309,314		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	61,006	0	61,006		62.00
65.00	06500	RESPIRATORY THERAPY	752,738	0	752,738		65.00
66.00	06600	PHYSICAL THERAPY	343,894	0	343,894		66.00
67.00	06700	OCCUPATIONAL THERAPY	308,569	0	308,569		67.00
68.00	06800	SPEECH PATHOLOGY	40,959	0	40,959		68.00
69.00	06900	ELECTROCARDIOLOGY	274,944	0	274,944		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	268,570	0	268,570		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	135,696	0	135,696		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,710,823	0	1,710,823		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	3,321,758	0	3,321,758		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,279,871	0	21,279,871		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	13,680	0	13,680		190.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	WELLNESS CENTER	144,037	0	144,037		193.01
193.02	19302	RETAIL PHARMACY	38,243	0	38,243		193.02
194.00	07950	OTHER NRCC	806,779	0	806,779		194.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	22,282,610	0	22,282,610		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/26/2016 9:14 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS 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	790	92	882	882	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	784,069	25,409	2,957	812,435	108	5.00
7.00	00700	OPERATION OF PLANT	93,288	78,525	9,139	180,952	49	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	995	116	1,111	0	8.00
9.00	00900	HOUSEKEEPING	1,010	949	110	2,069	25	9.00
10.00	01000	DIETARY	2,180	1,868	217	4,265	7	10.00
11.00	01100	CAFETERIA	0	4,818	561	5,379	18	11.00
13.00	01300	NURSING ADMINISTRATION	6,272	210	24	6,506	4	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,384	3,887	452	5,723	10	14.00
15.00	01500	PHARMACY	3,862	1,537	179	5,578	26	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,307	385	3,692	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,273	25,386	2,954	64,613	142	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	116,683	18,768	2,184	137,635	83	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	361,070	12,110	1,409	374,589	134	54.00
57.00	05700	CT SCAN	157,009	1,064	124	158,197	0	57.00
58.00	05800	MRI	33,608	992	115	34,715	11	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	15,868	5,582	650	22,100	57	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	10,835	6,254	728	17,817	35	65.00
66.00	06600	PHYSICAL THERAPY	6,541	4,446	517	11,504	9	66.00
67.00	06700	OCCUPATIONAL THERAPY	399	640	74	1,113	16	67.00
68.00	06800	SPEECH PATHOLOGY	0	640	74	714	2	68.00
69.00	06900	ELECTROCARDIOLOGY	17,609	1,234	144	18,987	10	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	54,634	7,774	905	63,313	125	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,702,594	207,185	24,110	1,933,889	871	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	617	72	689	0	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	19,869	0	0	19,869	7	193.01
193.02	19302	RETAIL PHARMACY	0	0	0	0	0	193.02
194.00	07950	OTHER NRCC	45,347	36,406	4,237	85,990	4	194.00
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)	1,767,810	244,208	28,419	2,040,437	882	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/26/2016 9:14 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	812,543					5.00
7.00	00700	OPERATION OF PLANT	76,333	257,334				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	67	1,835	3,013			8.00
9.00	00900	HOUSEKEEPING	19,250	1,750	0	23,094		9.00
10.00	01000	DIETARY	5,681	3,447	0	424	13,824	10.00
11.00	01100	CAFETERIA	10,278	8,889	0	1,093	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,434	388	0	48	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,713	7,171	0	882	0	14.00
15.00	01500	PHARMACY	18,710	2,835	0	349	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,931	6,102	0	750	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	90,170	46,833	3,013	5,759	13,824	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	79,046	34,625	0	4,258	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	595	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	149,719	22,342	0	2,748	0	54.00
57.00	05700	CT SCAN	16,523	1,963	0	241	0	57.00
58.00	05800	MRI	15,438	1,830	0	225	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	75,055	10,299	0	1,267	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	2,162	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	21,597	11,538	0	1,419	0	65.00
66.00	06600	PHYSICAL THERAPY	8,702	8,203	0	1,009	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,427	1,181	0	145	0	67.00
68.00	06800	SPEECH PATHOLOGY	935	1,181	0	145	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,111	2,277	0	280	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	6,843	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,745	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,614	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	104,766	14,342	0	1,764	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	796,845	189,031	3,013	22,806	13,824	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	41	1,138	0	140	0	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	5,082	0	0	0	0	193.01
193.02	19302	RETAIL PHARMACY	1,394	0	0	0	0	193.02
194.00	07950	OTHER NRCC	9,181	67,165	0	148	0	194.00
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)	812,543	257,334	3,013	23,094	13,824	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/26/2016 9:14 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		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
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	25,657					11.00
13.00	01300	NURSING ADMINISTRATION	324	10,704				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	600	0	22,099			14.00
15.00	01500	PHARMACY	765	0	14	28,277		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	31,475	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,612	4,511	1,772	0	1,977	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,944	2,152	9,171	0	3,122	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	183	0	794	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,674	0	1,244	0	3,477	54.00
57.00	05700	CT SCAN	0	0	20	0	3,426	57.00
58.00	05800	MRI	291	0	10	0	1,127	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,447	0	374	0	4,725	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	84	62.00
65.00	06500	RESPIRATORY THERAPY	1,415	0	310	0	401	65.00
66.00	06600	PHYSICAL THERAPY	438	0	40	0	385	66.00
67.00	06700	OCCUPATIONAL THERAPY	426	0	31	0	143	67.00
68.00	06800	SPEECH PATHOLOGY	48	0	11	0	70	68.00
69.00	06900	ELECTROCARDIOLOGY	348	0	48	0	1,061	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	5,641	0	219	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	203	0	139	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,277	3,368	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,665	4,041	3,021	0	6,957	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,997	10,704	22,093	28,277	31,475	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	315	0	0	0	0	193.01
193.02	19302	RETAIL PHARMACY	0	0	0	0	0	193.02
194.00	07950	OTHER NRCC	345	0	6	0	0	194.00
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)	25,657	10,704	22,099	28,277	31,475	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/26/2016 9:14 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	238,226	0	238,226		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	273,036	0	273,036		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	1,572	0	1,572		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	558,927	0	558,927		54.00
57.00	05700	CT SCAN	180,370	0	180,370		57.00
58.00	05800	MRI	53,647	0	53,647		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	116,324	0	116,324		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	2,246	0	2,246		62.00
65.00	06500	RESPIRATORY THERAPY	54,532	0	54,532		65.00
66.00	06600	PHYSICAL THERAPY	30,290	0	30,290		66.00
67.00	06700	OCCUPATIONAL THERAPY	13,482	0	13,482		67.00
68.00	06800	SPEECH PATHOLOGY	3,106	0	3,106		68.00
69.00	06900	ELECTROCARDIOLOGY	31,122	0	31,122		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	12,703	0	12,703		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,087	0	5,087		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,259	0	71,259		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	202,994	0	202,994		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,848,923	0	1,848,923		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	2,008	0	2,008		190.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	WELLNESS CENTER	25,273	0	25,273		193.01
193.02	19302	RETAIL PHARMACY	1,394	0	1,394		193.02
194.00	07950	OTHER NRCC	162,839	0	162,839		194.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	2,040,437	0	2,040,437		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 9:14 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	84,693					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		84,693				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	274	274	6,677,241			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,812	8,812	819,830	-8,732,773	13,549,837	5.00
7.00	00700	OPERATION OF PLANT	27,232	27,232	374,753	0	1,272,910	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	345	345	0	0	1,111	8.00
9.00	00900	HOUSEKEEPING	329	329	185,903	0	321,014	9.00
10.00	01000	DIETARY	648	648	51,010	0	94,730	10.00
11.00	01100	CAFETERIA	1,671	1,671	133,534	0	171,396	11.00
13.00	01300	NURSING ADMINISTRATION	73	73	32,407	0	57,259	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,348	1,348	77,775	0	128,621	14.00
15.00	01500	PHARMACY	533	533	195,227	0	312,010	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,147	1,147	0	0	349,042	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,804	8,804	1,087,773	0	1,503,666	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,509	6,509	625,521	0	1,318,156	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	9,930	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,200	4,200	1,013,193	0	2,496,684	54.00
57.00	05700	CT SCAN	369	369	2,718	0	275,540	57.00
58.00	05800	MRI	344	344	82,074	0	257,444	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,936	1,936	428,559	0	1,251,599	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	36,059	62.00
65.00	06500	RESPIRATORY THERAPY	2,169	2,169	261,611	0	360,147	65.00
66.00	06600	PHYSICAL THERAPY	1,542	1,542	65,491	0	145,106	66.00
67.00	06700	OCCUPATIONAL THERAPY	222	222	122,643	0	173,871	67.00
68.00	06800	SPEECH PATHOLOGY	222	222	11,667	0	15,599	68.00
69.00	06900	ELECTROCARDIOLOGY	428	428	79,443	0	135,252	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	114,119	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	79,124	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	660,591	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,696	2,696	945,207	0	1,747,069	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,853	71,853	6,596,339	-8,732,773	13,288,049	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	214	214	0	0	689	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	0	0	51,318	0	84,753	193.01
193.02	19302	RETAIL PHARMACY	0	0	0	0	23,252	193.02
194.00	07950	OTHER NRCC	12,626	12,626	29,584	0	153,094	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	244,208	28,419	1,192,123		8,732,773	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.883450	0.335553	0.178535		0.644493	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			882		812,543	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000132		0.059967	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 9:14 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	48,375					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	345	1,655				8.00
9.00	00900	HOUSEKEEPING	329	0	35,301			9.00
10.00	01000	DIETARY	648	0	648	1,655		10.00
11.00	01100	CAFETERIA	1,671	0	1,671	0	8,557	11.00
13.00	01300	NURSING ADMINISTRATION	73	0	73	0	108	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,348	0	1,348	0	200	14.00
15.00	01500	PHARMACY	533	0	533	0	255	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,147	0	1,147	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,804	1,655	8,804	1,655	1,872	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,509	0	6,509	0	982	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,200	0	4,200	0	1,559	54.00
57.00	05700	CT SCAN	369	0	369	0	0	57.00
58.00	05800	MRI	344	0	344	0	97	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,936	0	1,936	0	816	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,169	0	2,169	0	472	65.00
66.00	06600	PHYSICAL THERAPY	1,542	0	1,542	0	146	66.00
67.00	06700	OCCUPATIONAL THERAPY	222	0	222	0	142	67.00
68.00	06800	SPEECH PATHOLOGY	222	0	222	0	16	68.00
69.00	06900	ELECTROCARDIOLOGY	428	0	428	0	116	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,696	0	2,696	0	1,556	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	35,535	1,655	34,861	1,655	8,337	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	214	0	214	0	0	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	0	0	0	0	105	193.01
193.02	19302	RETAIL PHARMACY	0	0	0	0	0	193.02
194.00	07950	OTHER NRCC	12,626	0	226	0	115	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,093,292	16,756	542,142	193,775	379,831	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.272186	10.124471	15.357695	117.084592	44.388337	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	257,334	3,013	23,094	13,824	25,657	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.319566	1.820544	0.654202	8.352870	2.998364	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 9:14 am

		Cost Center Description	NURSING ADMINISTRATION (TOTAL NURSING SALAR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,726,530					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	773,303				14.00
15.00	01500	PHARMACY	0	482	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	85,518,811		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	727,607	61,999	0	5,371,982		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	347,169	320,920	0	8,484,006		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	6,392	0	2,158,585		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	43,533	0	9,449,160		54.00
57.00	05700	CT SCAN	0	705	0	9,308,698		57.00
58.00	05800	MRI	0	353	0	3,063,765		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	13,098	0	12,839,146		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	227,707		62.00
65.00	06500	RESPIRATORY THERAPY	0	10,841	0	1,088,594		65.00
66.00	06600	PHYSICAL THERAPY	0	1,394	0	1,045,527		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,074	0	387,454		67.00
68.00	06800	SPEECH PATHOLOGY	0	376	0	191,493		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,687	0	2,884,507		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	197,390	0	596,453		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,097	0	377,244		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	9,153,362		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	651,754	105,730	0	18,891,128		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,726,530	773,071	100	85,518,811		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	WELLNESS CENTER	0	0	0	0		193.01
193.02	19302	RETAIL PHARMACY	0	13	0	0		193.02
194.00	07950	OTHER NRCC	0	219	0	0		194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	103,236	299,427	555,854	641,245		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.059794	0.387205	5,558.540000	0.007498		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,704	22,099	28,277	31,475		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006200	0.028577	282.770000	0.000368		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 9:14 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,390,363		3,390,363	0	3,390,363	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,801,542		2,801,542	0	2,801,542	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	34,990		34,990	0	34,990	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,508,928		4,508,928	0	4,508,928	54.00
57.00	05700	CT SCAN	544,828		544,828	0	544,828	57.00
58.00	05800	MRI	470,949		470,949	0	470,949	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,309,314		2,309,314	0	2,309,314	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	61,006		61,006	0	61,006	62.00
65.00	06500	RESPIRATORY THERAPY	752,738	0	752,738	0	752,738	65.00
66.00	06600	PHYSICAL THERAPY	343,894	0	343,894	0	343,894	66.00
67.00	06700	OCCUPATIONAL THERAPY	308,569	0	308,569	0	308,569	67.00
68.00	06800	SPEECH PATHOLOGY	40,959	0	40,959	0	40,959	68.00
69.00	06900	ELECTROCARDIOLOGY	274,944		274,944	0	274,944	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	268,570		268,570	0	268,570	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	135,696		135,696	0	135,696	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,710,823		1,710,823	0	1,710,823	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,321,758		3,321,758	167,512	3,489,270	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1,295,383		1,295,383		1,295,383	92.00
200.00		Subtotal (see instructions)	22,575,254	0	22,575,254	167,512	22,742,766	200.00
201.00		Less Observation Beds	1,295,383		1,295,383		1,295,383	201.00
202.00		Total (see instructions)	21,279,871	0	21,279,871	167,512	21,447,383	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 9:14 am

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		Cost Center Description	Charges Inpatient	Charges 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	2,817,597		2,817,597			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	915,202	7,563,463	8,478,665	0.330423	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	171,838	1,985,388	2,157,226	0.016220	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	356,259	9,086,953	9,443,212	0.477478	0.000000	54.00
57.00	05700	CT SCAN	773,292	8,529,546	9,302,838	0.058566	0.000000	57.00
58.00	05800	MRI	119,554	2,942,282	3,061,836	0.153813	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,561,788	11,269,276	12,831,064	0.179978	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	43,018	184,546	227,564	0.268083	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	631,427	456,482	1,087,909	0.691913	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	42,144	1,002,725	1,044,869	0.329126	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,161	357,049	387,210	0.796903	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	17,025	174,347	191,372	0.214028	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	368,047	2,514,644	2,882,691	0.095378	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	263,418	332,660	596,078	0.450562	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,725	354,282	377,007	0.359930	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,606,084	6,541,516	9,147,600	0.187024	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	1,207,993	12,085,770	13,293,763	0.249873	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	360,905	2,190,098	2,551,003	0.507794	0.000000	92.00
200.00		Subtotal (see instructions)	12,308,477	67,571,027	79,879,504			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,308,477	67,571,027	79,879,504			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 9:14 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.330423	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.016220	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.477478	54.00
57.00	05700	CT SCAN	0.058566	57.00
58.00	05800	MRI	0.153813	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.179978	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.268083	62.00
65.00	06500	RESPIRATORY THERAPY	0.691913	65.00
66.00	06600	PHYSICAL THERAPY	0.329126	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.796903	67.00
68.00	06800	SPEECH PATHOLOGY	0.214028	68.00
69.00	06900	ELECTROCARDIOLOGY	0.095378	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.450562	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.359930	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187024	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.262474	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.507794	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 9:14 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,390,363		3,390,363	0	3,390,363	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,801,542		2,801,542	0	2,801,542	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	34,990		34,990	0	34,990	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,508,928		4,508,928	0	4,508,928	54.00
57.00	05700	CT SCAN	544,828		544,828	0	544,828	57.00
58.00	05800	MRI	470,949		470,949	0	470,949	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,309,314		2,309,314	0	2,309,314	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	61,006		61,006	0	61,006	62.00
65.00	06500	RESPIRATORY THERAPY	752,738	0	752,738	0	752,738	65.00
66.00	06600	PHYSICAL THERAPY	343,894	0	343,894	0	343,894	66.00
67.00	06700	OCCUPATIONAL THERAPY	308,569	0	308,569	0	308,569	67.00
68.00	06800	SPEECH PATHOLOGY	40,959	0	40,959	0	40,959	68.00
69.00	06900	ELECTROCARDIOLOGY	274,944		274,944	0	274,944	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	268,570		268,570	0	268,570	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	135,696		135,696	0	135,696	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,710,823		1,710,823	0	1,710,823	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,321,758		3,321,758	167,512	3,489,270	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1,295,383		1,295,383		1,295,383	92.00
200.00		Subtotal (see instructions)	22,575,254	0	22,575,254	167,512	22,742,766	200.00
201.00		Less Observation Beds	1,295,383		1,295,383		1,295,383	201.00
202.00		Total (see instructions)	21,279,871	0	21,279,871	167,512	21,447,383	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 9:14 am

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		Cost Center Description	Charges Inpatient	Charges 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	2,817,597		2,817,597			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	915,202	7,563,463	8,478,665	0.330423	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	171,838	1,985,388	2,157,226	0.016220	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	356,259	9,086,953	9,443,212	0.477478	0.000000	54.00
57.00	05700	CT SCAN	773,292	8,529,546	9,302,838	0.058566	0.000000	57.00
58.00	05800	MRI	119,554	2,942,282	3,061,836	0.153813	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,561,788	11,269,276	12,831,064	0.179978	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	43,018	184,546	227,564	0.268083	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	631,427	456,482	1,087,909	0.691913	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	42,144	1,002,725	1,044,869	0.329126	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,161	357,049	387,210	0.796903	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	17,025	174,347	191,372	0.214028	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	368,047	2,514,644	2,882,691	0.095378	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	263,418	332,660	596,078	0.450562	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,725	354,282	377,007	0.359930	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,606,084	6,541,516	9,147,600	0.187024	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	1,207,993	12,085,770	13,293,763	0.249873	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	360,905	2,190,098	2,551,003	0.507794	0.000000	92.00
200.00		Subtotal (see instructions)	12,308,477	67,571,027	79,879,504			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,308,477	67,571,027	79,879,504			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 9:14 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
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.330423		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.016220		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.477478		54.00
57.00	05700	CT SCAN	0.058566		57.00
58.00	05800	MRI	0.153813		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.179978		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.268083		62.00
65.00	06500	RESPIRATORY THERAPY	0.691913		65.00
66.00	06600	PHYSICAL THERAPY	0.329126		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.796903		67.00
68.00	06800	SPEECH PATHOLOGY	0.214028		68.00
69.00	06900	ELECTROCARDIOLOGY	0.095378		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.450562		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.359930		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187024		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.262474		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.507794		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II | Date/Time Prepared: 5/26/2016 9:14 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	2,801,542	273,036	2,528,506	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	34,990	1,572	33,418	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,508,928	558,927	3,950,001	0	0	54.00
57.00	05700	CT SCAN	544,828	180,370	364,458	0	0	57.00
58.00	05800	MRI	470,949	53,647	417,302	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,309,314	116,324	2,192,990	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	61,006	2,246	58,760	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	752,738	54,532	698,206	0	0	65.00
66.00	06600	PHYSICAL THERAPY	343,894	30,290	313,604	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	308,569	13,482	295,087	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	40,959	3,106	37,853	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	274,944	31,122	243,822	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	268,570	12,703	255,867	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	135,696	5,087	130,609	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,710,823	71,259	1,639,564	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,321,758	202,994	3,118,764	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1,295,383	91,021	1,204,362	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	19,184,891	1,701,718	17,483,173	0	0	200.00
201.00		Less Observation Beds	1,295,383	91,021	1,204,362	0	0	201.00
202.00		Total (line 200 minus line 201)	17,889,508	1,610,697	16,278,811	0	0	202.00

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

Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II Date/Time Prepared: 5/26/2016 9:14 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	2,801,542	8,478,665	0.330423		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	34,990	2,157,226	0.016220		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,508,928	9,443,212	0.477478		54.00
57.00	05700	CT SCAN	544,828	9,302,838	0.058566		57.00
58.00	05800	MRI	470,949	3,061,836	0.153813		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000	LABORATORY	2,309,314	12,831,064	0.179978		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	61,006	227,564	0.268083		62.00
65.00	06500	RESPIRATORY THERAPY	752,738	1,087,909	0.691913		65.00
66.00	06600	PHYSICAL THERAPY	343,894	1,044,869	0.329126		66.00
67.00	06700	OCCUPATIONAL THERAPY	308,569	387,210	0.796903		67.00
68.00	06800	SPEECH PATHOLOGY	40,959	191,372	0.214028		68.00
69.00	06900	ELECTROCARDIOLOGY	274,944	2,882,691	0.095378		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	268,570	596,078	0.450562		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	135,696	377,007	0.359930		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,710,823	9,147,600	0.187024		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
91.00	09100	EMERGENCY	3,321,758	13,293,763	0.249873		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1,295,383	2,551,003	0.507794		92.00
200.00		Subtotal (sum of lines 50 thru 199)	19,184,891	77,061,907			200.00
201.00		Less Observation Beds	1,295,383	0			201.00
202.00		Total (line 200 minus line 201)	17,889,508	77,061,907			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I Date/Time Prepared: 5/26/2016 9:14 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	238,226	0	238,226	2,667	89.32	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
200.00	Total (lines 30-199)	238,226		238,226	2,667		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	936	83,604		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
200.00	Total (lines 30-199)	936	83,604		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/26/2016 9:14 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	273,036	8,478,665	0.032203	373,490	12,027	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1,572	2,157,226	0.000729	71,486	52	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	558,927	9,443,212	0.059188	205,677	12,174	54.00
57.00	05700	CT SCAN	180,370	9,302,838	0.019389	479,706	9,301	57.00
58.00	05800	MRI	53,647	3,061,836	0.017521	72,691	1,274	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	116,324	12,831,064	0.009066	976,897	8,857	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	2,246	227,564	0.009870	30,061	297	62.00
65.00	06500	RESPIRATORY THERAPY	54,532	1,087,909	0.050126	393,009	19,700	65.00
66.00	06600	PHYSICAL THERAPY	30,290	1,044,869	0.028989	30,968	898	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,482	387,210	0.034818	21,409	745	67.00
68.00	06800	SPEECH PATHOLOGY	3,106	191,372	0.016230	12,109	197	68.00
69.00	06900	ELECTROCARDIOLOGY	31,122	2,882,691	0.010796	245,193	2,647	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	12,703	596,078	0.021311	185,204	3,947	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,087	377,007	0.013493	3,311	45	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,259	9,147,600	0.007790	1,467,218	11,430	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	202,994	13,293,763	0.015270	672,624	10,271	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	91,021	2,551,003	0.035680	199,577	7,121	92.00
200.00		Total (lines 50-199)	1,701,718	77,061,907		5,440,630	100,983	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/26/2016 9:14 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
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
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	2,667	0.00	936	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
200.00		Total (lines 30-199)	2,667		936	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 9:14 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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 PAT	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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
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: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 9:14 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	8,478,665	0.000000	0.000000	373,490	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	2,157,226	0.000000	0.000000	71,486	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,443,212	0.000000	0.000000	205,677	54.00
57.00	05700	CT SCAN	0	9,302,838	0.000000	0.000000	479,706	57.00
58.00	05800	MRI	0	3,061,836	0.000000	0.000000	72,691	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	12,831,064	0.000000	0.000000	976,897	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	227,564	0.000000	0.000000	30,061	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,087,909	0.000000	0.000000	393,009	65.00
66.00	06600	PHYSICAL THERAPY	0	1,044,869	0.000000	0.000000	30,968	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	387,210	0.000000	0.000000	21,409	67.00
68.00	06800	SPEECH PATHOLOGY	0	191,372	0.000000	0.000000	12,109	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,882,691	0.000000	0.000000	245,193	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	596,078	0.000000	0.000000	185,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	377,007	0.000000	0.000000	3,311	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,147,600	0.000000	0.000000	1,467,218	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	13,293,763	0.000000	0.000000	672,624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	2,551,003	0.000000	0.000000	199,577	92.00
200.00		Total (lines 50-199)	0	77,061,907			5,440,630	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/26/2016 9:14 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	2,543,944	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	729,355	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,213,516	0		54.00
57.00	05700	CT SCAN	0	2,716,406	0		57.00
58.00	05800	MRI	0	875,418	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	2,056,892	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	84,240	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	163,248	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	729	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,007,320	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	159,728	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	145,863	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,479,679	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	3,137,902	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	1,035,606	0		92.00
200.00		Total (lines 50-199)	0	19,349,846	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/26/2016 9:14 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	0.330423	2,543,944	0	0	840,578	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.016220	729,355	0	0	11,830	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.477478	2,213,516	0	0	1,056,905	54.00
57.00	05700	CT SCAN	0.058566	2,716,406	0	0	159,089	57.00
58.00	05800	MRI	0.153813	875,418	0	0	134,651	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.179978	2,056,892	0	0	370,195	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.268083	84,240	0	0	22,583	62.00
65.00	06500	RESPIRATORY THERAPY	0.691913	163,248	0	0	112,953	65.00
66.00	06600	PHYSICAL THERAPY	0.329126	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.796903	729	0	0	581	67.00
68.00	06800	SPEECH PATHOLOGY	0.214028	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.095378	1,007,320	0	0	96,076	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.450562	159,728	0	0	71,967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.359930	145,863	0	0	52,500	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187024	2,479,679	0	50,595	463,759	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.249873	3,137,902	0	0	784,077	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.507794	1,035,606	0	0	525,875	92.00
200.00		Subtotal (see instructions)		19,349,846	0	50,595	4,703,619	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		19,349,846	0	50,595	4,703,619	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/26/2016 9:14 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,462		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00		Subtotal (see instructions)	0	9,462		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	9,462		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I Date/Time Prepared: 5/26/2016 9:14 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	238,226	0	238,226	2,667	89.32	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
200.00	Total (lines 30-199)	238,226		238,226	2,667		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	289	25,813		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
200.00	Total (lines 30-199)	289	25,813		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/26/2016 9:14 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	273,036	8,478,665	0.032203	44,338	1,428	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1,572	2,157,226	0.000729	9,030	7	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	558,927	9,443,212	0.059188	15,735	931	54.00
57.00	05700	CT SCAN	180,370	9,302,838	0.019389	35,862	695	57.00
58.00	05800	MRI	53,647	3,061,836	0.017521	3,070	54	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	116,324	12,831,064	0.009066	71,948	652	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	2,246	227,564	0.009870	1,274	13	62.00
65.00	06500	RESPIRATORY THERAPY	54,532	1,087,909	0.050126	30,741	1,541	65.00
66.00	06600	PHYSICAL THERAPY	30,290	1,044,869	0.028989	1,441	42	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,482	387,210	0.034818	327	11	67.00
68.00	06800	SPEECH PATHOLOGY	3,106	191,372	0.016230	230	4	68.00
69.00	06900	ELECTROCARDIOLOGY	31,122	2,882,691	0.010796	12,091	131	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	12,703	596,078	0.021311	9,421	201	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,087	377,007	0.013493	3,208	43	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,259	9,147,600	0.007790	154,622	1,205	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	202,994	13,293,763	0.015270	42,976	656	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	91,021	2,551,003	0.035680	33,544	1,197	92.00
200.00		Total (lines 50-199)	1,701,718	77,061,907		469,858	8,811	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/26/2016 9:14 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
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
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	2,667	0.00	289	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
200.00		Total (lines 30-199)	2,667		289	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 9:14 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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 PAT	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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
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: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 9:14 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	8,478,665	0.000000	0.000000	44,338	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	2,157,226	0.000000	0.000000	9,030	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,443,212	0.000000	0.000000	15,735	54.00
57.00	05700	CT SCAN	0	9,302,838	0.000000	0.000000	35,862	57.00
58.00	05800	MRI	0	3,061,836	0.000000	0.000000	3,070	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	12,831,064	0.000000	0.000000	71,948	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	227,564	0.000000	0.000000	1,274	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,087,909	0.000000	0.000000	30,741	65.00
66.00	06600	PHYSICAL THERAPY	0	1,044,869	0.000000	0.000000	1,441	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	387,210	0.000000	0.000000	327	67.00
68.00	06800	SPEECH PATHOLOGY	0	191,372	0.000000	0.000000	230	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,882,691	0.000000	0.000000	12,091	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	596,078	0.000000	0.000000	9,421	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	377,007	0.000000	0.000000	3,208	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,147,600	0.000000	0.000000	154,622	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	13,293,763	0.000000	0.000000	42,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	2,551,003	0.000000	0.000000	33,544	92.00
200.00		Total (lines 50-199)	0	77,061,907			469,858	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 9:14 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
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/26/2016 9:14 am

Title XIX | 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	0.330423	0	456,496	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.016220	0	103,309	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.477478	0	449,868	0	0	54.00
57.00	05700	CT SCAN	0.058566	0	551,051	0	0	57.00
58.00	05800	MRI	0.153813	0	268,827	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.179978	0	776,765	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.268083	0	944	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.691913	0	28,035	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.329126	0	58,202	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.796903	0	40,425	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.214028	0	34,126	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.095378	0	142,753	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.450562	0	16,069	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.359930	0	9,513	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187024	0	480,228	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.249873	0	1,097,513	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.507794	0	266,551	0	0	92.00
200.00		Subtotal (see instructions)		0	4,780,675	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	4,780,675	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/26/2016 9:14 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	150,837	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	1,676	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	214,802	0		54.00
57.00	05700	CT SCAN	32,273	0		57.00
58.00	05800	MRI	41,349	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	139,801	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	253	0		62.00
65.00	06500	RESPIRATORY THERAPY	19,398	0		65.00
66.00	06600	PHYSICAL THERAPY	19,156	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	32,215	0		67.00
68.00	06800	SPEECH PATHOLOGY	7,304	0		68.00
69.00	06900	ELECTROCARDIOLOGY	13,615	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	7,240	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,424	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	89,814	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	274,239	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	135,353	0		92.00
200.00		Subtotal (see instructions)	1,182,749	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,182,749	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 9:14 am

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	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)	2,667	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,667	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)	1,648	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)	936	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,390,363	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,390,363	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,390,363	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)	1,271.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,189,871	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)	1,189,871	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 9:14 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,408,022	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,597,893	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)	83,604	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	100,983	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	184,587	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,413,306	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)	1,019	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,271.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,295,383	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 9:14 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	238,226	3,390,363	0.070266	1,295,383	91,021	90.00
91.00	Nursing School cost	0	3,390,363	0.000000	1,295,383	0	91.00
92.00	Allied health cost	0	3,390,363	0.000000	1,295,383	0	92.00
93.00	All other Medical Education	0	3,390,363	0.000000	1,295,383	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 9:14 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)	2,667	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,667	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)	1,648	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)	289	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,390,363	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,390,363	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,390,363	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)	1,271.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	367,385	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)	367,385	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 9:14 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	124,010	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	491,395	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)	25,813	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	8,811	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	34,624	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	456,771	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)	1,019	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,271.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,295,383	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 9:14 am

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	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	238,226	3,390,363	0.070266	1,295,383	91,021	90.00
91.00	Nursing School cost	0	3,390,363	0.000000	1,295,383	0	91.00
92.00	Allied health cost	0	3,390,363	0.000000	1,295,383	0	92.00
93.00	All other Medical Education	0	3,390,363	0.000000	1,295,383	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/26/2016 9:14 am

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		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,275,970		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.330423	373,490	123,410	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.016220	71,486	1,160	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.477478	205,677	98,206	54.00
57.00	05700	CT SCAN	0.058566	479,706	28,094	57.00
58.00	05800	MRI	0.153813	72,691	11,181	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.179978	976,897	175,820	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.268083	30,061	8,059	62.00
65.00	06500	RESPIRATORY THERAPY	0.691913	393,009	271,928	65.00
66.00	06600	PHYSICAL THERAPY	0.329126	30,968	10,192	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.796903	21,409	17,061	67.00
68.00	06800	SPEECH PATHOLOGY	0.214028	12,109	2,592	68.00
69.00	06900	ELECTROCARDIOLOGY	0.095378	245,193	23,386	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.450562	185,204	83,446	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.359930	3,311	1,192	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187024	1,467,218	274,405	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.262474	672,624	176,546	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.507794	199,577	101,344	92.00
200.00		Total (sum of lines 50-94 and 96-98)		5,440,630	1,408,022	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)		5,440,630		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/26/2016 9:14 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		109,280		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.330423	44,338	14,650	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.016220	9,030	146	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.477478	15,735	7,513	54.00
57.00	05700	CT SCAN	0.058566	35,862	2,100	57.00
58.00	05800	MRI	0.153813	3,070	472	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.179978	71,948	12,949	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.268083	1,274	342	62.00
65.00	06500	RESPIRATORY THERAPY	0.691913	30,741	21,270	65.00
66.00	06600	PHYSICAL THERAPY	0.329126	1,441	474	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.796903	327	261	67.00
68.00	06800	SPEECH PATHOLOGY	0.214028	230	49	68.00
69.00	06900	ELECTROCARDIOLOGY	0.095378	12,091	1,153	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.450562	9,421	4,245	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.359930	3,208	1,155	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187024	154,622	28,918	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.262474	42,976	11,280	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.507794	33,544	17,033	92.00
200.00		Total (sum of lines 50-94 and 96-98)		469,858	124,010	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)		469,858		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 5/26/2016 9:14 am

Title XVIII | Hospital | PPS

		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		1,474,688		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		258,920		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)		16,725		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		206,519		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		47.21		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)		8.01		30.00
31.00	Percentage of Medicaid patient days (see instructions)		17.46		31.00
32.00	Sum of lines 30 and 31		25.47		32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.23		33.00
34.00	Disproportionate share adjustment (see instructions)		44,337		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A | Date/Time Prepared: 5/26/2016 9:14 am

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	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)		0.000009812	0.000011127	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		75,041	71,284	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		56,127	17,918	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		74,045		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)		1,868,715		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		1,663,907		48.00
49.00	Total payment for inpatient operating costs (see instructions)		1,868,715		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		139,064		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)		2,007,779		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		2,007,779		61.00
62.00	Deductibles billed to program beneficiaries		268,160		62.00
63.00	Coinsurance billed to program beneficiaries		2,835		63.00
64.00	Allowable bad debts (see instructions)		15,593		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		10,135		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		15,593		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		1,746,919		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		2,819		70.93
70.94	HRR adjustment amount (see instructions)		-8,111		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 5/26/2016 9:14 am

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2015	360,508		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	66,039		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)		2,168,174		71.00
71.01	Sequestration adjustment (see instructions)		43,363		71.01
72.00	Interim payments		2,126,791		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)		-1,980		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		3,737		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)	1.0009643990	1.0053960754	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)	0.9945	1.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150102	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/26/2016 9:14 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,462	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,703,619	2.00
3.00	PPS payments	2,953,453	3.00
4.00	Outlier payment (see instructions)	74,666	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9,462	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	50,595	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)	50,595	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)	50,595	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	41,133	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)	9,462	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)	3,028,119	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	686,990	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,350,591	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,350,591	30.00
31.00	Primary payer payments	103	31.00
32.00	Subtotal (line 30 minus line 31)	2,350,488	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)	133,330	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	86,665	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	133,330	36.00
37.00	Subtotal (see instructions)	2,437,153	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)	2,437,153	40.00
40.01	Sequestration adjustment (see instructions)	48,743	40.01
41.00	Interim payments	2,297,909	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	90,501	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	528	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: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2016 9:14 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,126,791		2,297,909	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)		2,126,791		2,297,909	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		90,501	6.01
6.02	SETTLEMENT TO PROGRAM		1,980		0	6.02
7.00	Total Medicare program liability (see instructions)		2,124,811		2,388,410	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150102 | Component CCN: 15U102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2016 9:14 am

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		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)		0		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150102	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/26/2016 9:14 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	498	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	936	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	111	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,648	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	79,879,504	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,176,876	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)	326,550	8.00
9.00	Sequestration adjustment amount (see instructions)	6,531	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	320,019	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	379,015	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)	-58,996	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 150102 Component CCN: 15U102	Period: From 01/01/2015 To 12/31/2015	Worksheet E-2 Date/Time Prepared: 5/26/2016 9:14 am
	Title XVIII	Swing Beds - SNF	PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
20.00	Interim payments	0	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/26/2016 9:14 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,897,973	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	14,175,885	0	0	0	4.00
5.00	Other receivable	415,278	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,488,677	0	0	0	6.00
7.00	Inventory	343,397	0	0	0	7.00
8.00	Prepaid expenses	138,928	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)	8,482,784	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	142,789	0	0	0	12.00
13.00	Land improvements	37,448	0	0	0	13.00
14.00	Accumulated depreciation	-4,127	0	0	0	14.00
15.00	Buildings	6,649,386	0	0	0	15.00
16.00	Accumulated depreciation	-3,104,631	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,752,977	0	0	0	23.00
24.00	Accumulated depreciation	-6,904,127	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	6,569,715	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	788,066	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	788,066	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	15,840,565	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	705,933	0	0	0	37.00
38.00	Salaries, wages, and fees payable	473,491	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	23,143	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	65,959	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,268,526	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	24,579	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	24,579	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	1,293,105	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	14,547,460				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)	14,547,460	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	15,840,565	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/26/2016 9:14 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		8,502,910		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,044,550				2.00
3.00	Total (sum of line 1 and line 2)		14,547,460		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)		14,547,460		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		14,547,460		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 150102 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2016 9:14 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,440,722		5,440,722	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)	5,440,722		5,440,722	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	5,440,722		5,440,722	17.00
18.00	Ancillary services	7,960,838	53,236,758	61,197,596	18.00
19.00	Outpatient services	1,219,885	17,671,243	18,891,128	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NONREIMBURSABLE	128	26,804	26,932	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,621,573	70,934,805	85,556,378	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,750,720		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		19,750,720		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150102	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prepared: 5/26/2016 9:14 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	85,556,378	1.00
2.00	Less contractual allowances and discounts on patients' accounts	60,316,385	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,239,993	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	19,750,720	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,489,273	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,076	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	73,380	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	10,727	16.00
17.00	Revenue from sale of drugs to other than patients	19,111	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	42,741	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	406,242	24.00
25.00	Total other income (sum of lines 6-24)	555,277	25.00
26.00	Total (line 5 plus line 25)	6,044,550	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)	6,044,550	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150102	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/26/2016 9:14 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	138,183	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	881	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)	4.53	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)	139,064	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