

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  
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/30/2017 11:44 am
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/30/2017 Time: 11:44 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

**CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)**

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PINNACLE HOSPITAL ( 15-0166 ) 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 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	0	359	0	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	0	359	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-0166		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 11:43 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 9301 CONNECTICUT DRIVE			PO Box:							1.00	
2.00	City: CROWN POINT			State: IN		Zip Code: 46307		County: LAKE			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00		3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		PINNACLE HOSPITAL		150166	23844	1	08/01/2007	N	P	P	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2015	12/31/2015		20.00		
21.00	Type of Control (see instructions)						5			21.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N			22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						0	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.			0	0	0	0	0	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	0	25.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0166		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 11:43 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.		1					26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		1					27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0					35.00		
		Beginning:		Ending:						
		1.00		2.00						
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.		0					37.00		
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01		
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00		
		Y/N		Y/N						
		1.00		2.00						
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N		N			39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N		N			40.00		
		V		XVII		XIX				
		1.00		2.00		3.00				
<b>Prospective Payment System (PPS)-Capital</b>										
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		
<b>Teaching Hospitals</b>										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N					56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		N					58.00		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N					59.00		
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)		N					60.00		
		Y/N		IME		Direct GME				
		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

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	0.00	0.00				61.06
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.20	
					1.00		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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				
64.00	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. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
		1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 67.00	
				1.00	2.00	3.00	
<b>Inpatient Psychiatric Facility PPS</b>							
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	
<b>Inpatient Rehabilitation Facility PPS</b>							
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			
<b>Long Term Care Hospital PPS</b>							
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	
<b>TEFRA Providers</b>							
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		
<b>Title V and XIX Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N		94.00

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		V		XIX			
		1.00		2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00	
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.					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		Speech		Respiratory	
		1.00		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.					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	
<b>Miscellaneous Cost Reporting Information</b>							
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	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118.00	
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	108,446		0		0	
						1.00	
						2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
<b>Transplant Center Information</b>							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0166		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 11:43 am	
		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00	2.00				
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		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	
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name	County	State	Zip Code	CBSA	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
						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.			N		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)			0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 11:43 am
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00



HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0166		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 11:43 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				
		1.00	2.00				
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				
		1.00	2.00				
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	07/30/2016			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y					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.			N			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/15/2016	Y	02/15/2016		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.	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 11:43 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
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
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
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	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00		2.00	
<b>Cost Report Preparer Contact Information</b>					
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.	KARRIE		PENCE	41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	816-751-1831		KARRIE.PENCE@MCGLADREY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 11:43 am
		3.00		
<b>Cost Report Preparer Contact Information</b>				
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.	SUPERVISOR		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: 15-0166

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2017 11:43 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					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	16	5,840	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)		16	5,840	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	2	538	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)		18	6,378	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	89.00				0	26.25
27.00 Total (sum of lines 14-26)		18				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: 15-0166

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2017 11:43 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,150	13	2,811			1.00
2.00 HMO and other (see instructions)	0	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)	1,150	13	2,811			7.00
8.00 INTENSIVE CARE UNIT	6	0	36			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)	1,156	13	2,847	0.00	151.60	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	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	151.60	27.00
28.00 Observation Bed Days		9	607			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0166

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2017 11:43 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	312	8	815	1.00
2.00 HMO and other (see instructions)				0	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	312	8	815		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	0.00						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: 15-0166

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/30/2017 11:43 am

	Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	8,071,930	-828,146	7,243,784	309,163.00	23.43
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		609,075	-49,008	560,067	12,325.00	45.44
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		283,858	0	283,858	3,885.00	73.07
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		1,557,156	0	1,557,156		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		64,657	0	64,657		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related						
25.51	Related organization wage-related						
25.52	Home office: Physician Part A - Administrative - wage-related						
25.53	Home office & Contract Physicians Part A - Teaching - wage-related						
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	82,089	0	82,089	4,547.00	18.05
27.00	Administrative & General	5.00	2,116,547	-299,514	1,817,033	59,676.00	30.45

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0166

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/30/2017 11:43 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	96,183	0	96,183	375.00	256.49	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	46,777	-4,537	42,240	2,080.00	20.31	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	103,167	-25,382	77,785	7,396.00	10.52	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	188,812	-27,834	160,978	9,486.00	16.97	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	0	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	169,910	-15,195	154,715	9,439.00	16.39	39.00
40.00	Pharmacy	421,329	-37,544	383,785	10,839.00	35.41	40.00
41.00	Medical Records & Medical Records Library	221,853	0	221,853	12,474.00	17.79	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00



HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 15-0166		Period: From 01/01/2015 To 12/31/2015		Worksheet S-3 Part III Date/Time Prepared: 5/30/2017 11:43 am	
	Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	8,168,113	-828,146	7,339,967	309,538.00	23.71	1.00
2.00	Excluded area salaries (see instructions)	609,075	-49,008	560,067	12,325.00	45.44	2.00
3.00	Subtotal salaries (line 1 minus line 2)	7,559,038	-779,138	6,779,900	297,213.00	22.81	3.00
4.00	Subtotal other wages & related costs (see inst.)	283,858	0	283,858	3,885.00	73.07	4.00
5.00	Subtotal wage-related costs (see inst.)	1,557,156	0	1,557,156	0.00	22.97	5.00
6.00	Total (sum of lines 3 thru 5)	9,400,052	-779,138	8,620,914	301,098.00	28.63	6.00
7.00	Total overhead cost (see instructions)	3,446,667	-410,006	3,036,661	116,312.00	26.11	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2017 11:43 am
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
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)	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
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
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	625,827	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	46,651	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	11,465	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)	38,430	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	454,905	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
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	444,534	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,621,812	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part V Date/Time Prepared: 5/30/2017 11:43 am
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	283,858	0	1.00
2.00	Hospital	283,858	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: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 5/30/2017 11:43 am
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.252595	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		148,541	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		1,083,066	6.00	
7.00	Medicaid cost (line 1 times line 6)		273,577	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)		125,036	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		651,037	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		164,449	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)		164,449	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		289,485	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
20.00	Charity care charges for the entire facility (see instructions)	0	0	0	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	0	0	0	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	0	0	0	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?				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)		302,474		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		0		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		302,474		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		76,403		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		76,403		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		365,888		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0166

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

Worksheet A  
Date/Time Prepared:  
5/30/2017 11:43 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT		313,331		313,331	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,127,978	224,176	1,352,154	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	82,089	672,043	0	754,132	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,116,547	6,564,030	-182,530	8,498,047	5.00
7.00	00700	OPERATION OF PLANT	46,777	694,994	-15,943	725,828	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	103,167	55,237	0	158,404	9.00
10.00	01000	DIETARY	188,812	48,419	0	237,231	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	169,910	286,175	0	456,085	14.00
15.00	01500	PHARMACY	421,329	30,734	0	452,063	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	221,853	80,247	0	302,100	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,403,446	598,702	-2,918	1,999,230	30.00
31.00	03100	INTENSIVE CARE UNIT	271,469	15,326	0	286,795	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,375,210	487,525	-12,028	1,850,707	50.00
53.00	05300	ANESTHESIOLOGY	0	216,228	0	216,228	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	565,953	122,574	-10,200	678,327	54.00
60.00	06000	LABORATORY	0	281,783	0	281,783	60.00
65.00	06500	RESPIRATORY THERAPY	309,861	70,702	-557	380,006	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,024,624	0	2,024,624	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,053,636	0	8,053,636	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	577,584	0	577,584	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001	URGENT CARE	186,432	288,314	0	474,746	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,462,855	22,610,186	0	30,073,041	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	609,075	954,278	0	1,563,353	192.00
194.00	07950	INDIANA BREAST CENTER	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	8,071,930	23,564,464	0	31,636,394	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0166

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

Worksheet A  
Date/Time Prepared:  
5/30/2017 11:43 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,030,027	1,343,358	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,352,154	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-9,969	744,163	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,977,131	5,520,916	5.00
7.00	00700	OPERATION OF PLANT	-2,925	722,903	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	158,404	9.00
10.00	01000	DIETARY	0	237,231	10.00
11.00	01100	CAFETERIA	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	456,085	14.00
15.00	01500	PHARMACY	0	452,063	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,647	300,453	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	1,999,230	30.00
31.00	03100	INTENSIVE CARE UNIT	0	286,795	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-496	1,850,211	50.00
53.00	05300	ANESTHESIOLOGY	-215,969	259	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	678,327	54.00
60.00	06000	LABORATORY	0	281,783	60.00
65.00	06500	RESPIRATORY THERAPY	0	380,006	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,024,624	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,053,636	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	577,584	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.01	09001	URGENT CARE	0	474,746	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,178,110	27,894,931	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,563,353	192.00
194.00	07950	INDIANA BREAST CENTER	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-2,178,110	29,458,284	200.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
<b>A - BENEFIT EXPENSE</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	299,514	1.00
2.00	OPERATION OF PLANT	7.00	0	4,537	2.00
3.00	HOUSEKEEPING	9.00	0	25,382	3.00
4.00	DIETARY	10.00	0	27,834	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	15,195	5.00
6.00	PHARMACY	15.00	0	37,544	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	119,196	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	51,755	8.00
9.00	OPERATING ROOM	50.00	0	126,209	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	45,807	10.00
11.00	RESPIRATORY THERAPY	65.00	0	26,165	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	49,008	12.00
	<b>0</b>		<b>0</b>	<b>828,146</b>	
<b>B - CAPITAL INTEREST EXPENSE</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	67,648	1.00
	<b>0</b>		<b>0</b>	<b>67,648</b>	
<b>C - RENTAL EXPENSE</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	156,528	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
	<b>0</b>		<b>0</b>	<b>156,528</b>	
500.00	Grand Total : Increases		0	1,052,322	500.00

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
<b>A - BENEFIT EXPENSE</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	299,514	0	0	1.00
2.00	OPERATION OF PLANT	7.00	4,537	0	0	2.00
3.00	HOUSEKEEPING	9.00	25,382	0	0	3.00
4.00	DIETARY	10.00	27,834	0	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	15,195	0	0	5.00
6.00	PHARMACY	15.00	37,544	0	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	119,196	0	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	51,755	0	0	8.00
9.00	OPERATING ROOM	50.00	126,209	0	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	45,807	0	0	10.00
11.00	RESPIRATORY THERAPY	65.00	26,165	0	0	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	49,008	0	0	12.00
	<b>O</b>		<b>828,146</b>	<b>0</b>		
<b>B - CAPITAL INTEREST EXPENSE</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	67,648	11	1.00
	<b>O</b>		<b>0</b>	<b>67,648</b>		
<b>C - RENTAL EXPENSE</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	114,882	10	1.00
2.00	OPERATION OF PLANT	7.00	0	15,943	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,918	0	3.00
4.00	OPERATING ROOM	50.00	0	12,028	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,200	0	5.00
6.00	RESPIRATORY THERAPY	65.00	0	557	0	6.00
	<b>O</b>		<b>0</b>	<b>156,528</b>		
500.00	<b>Grand Total : Decreases</b>		<b>828,146</b>	<b>224,176</b>		<b>500.00</b>



RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0166

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/30/2017 11:43 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	25,000	0	0	0	0	1.00
2.00	Land Improvements	292,424	0	0	0	0	2.00
3.00	Buildings and Fixtures	704,284	193,781	0	193,781	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	129,683	0	0	0	0	5.00
6.00	Movable Equipment	13,837,771	854,756	0	854,756	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,989,162	1,048,537	0	1,048,537	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	14,989,162	1,048,537	0	1,048,537	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	25,000	0				1.00
2.00	Land Improvements	292,424	0				2.00
3.00	Buildings and Fixtures	898,065	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	129,683	0				5.00
6.00	Movable Equipment	14,692,527	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	16,037,699	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	16,037,699	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0166

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/30/2017 11:43 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	597	0	0	0	312,734	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,093,533	0	0	34,445	0	2.00
3.00	Total (sum of lines 1-2)	1,094,130	0	0	34,445	312,734	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	313,331				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,127,978				2.00
3.00	Total (sum of lines 1-2)	0	1,441,309				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0166

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/30/2017 11:43 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	14,692,527	92	14,692,435	0.478113	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,037,699	100	16,037,599	0.521887	0 2.00
3.00	Total (sum of lines 1-2)	30,730,226	192	30,730,034	1.000000	0 3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
	Taxes	Other Capital-Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,030,624	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,093,533	156,528 2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,124,157	156,528 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 col.s. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	312,734	0	1,343,358 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	67,648	34,445	0	0	1,352,154 2.00
3.00	Total (sum of lines 1-2)	67,648	34,445	312,734	0	2,695,512 3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0166

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

Worksheet A-8

Date/Time Prepared:  
5/30/2017 11:43 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)				OCAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)				OCAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)	B	-3,055		ADMINISTRATIVE & GENERAL	5.00	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)	B	-12,823		ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-3,354		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-2,925		OPERATION OF PLANT	7.00	0	8.00
9.00 Parking lot (chapter 21)		0			0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-711,444				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	-769,794				0	12.00
13.00 Laundry and linen service		0			0.00	0	13.00
14.00 Cafeteria-employees and guests		0			0.00	0	14.00
15.00 Rental of quarters to employee and others		0			0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00 Sale of drugs to other than patients		0			0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-1,233		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00 Vending machines		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			ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			OPHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)				OUTILIZATION REVIEW-SNF	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT				OCAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP				OCAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist				ONONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant				0	0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3			OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)				OADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			OSPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 MISC REVENUE	B	-6,819		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01 FACILITY FEES	B	-27,322		ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0166

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

Worksheet A-8

Date/Time Prepared:  
5/30/2017 11:43 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.02 MISC REVENUE	B	-25,252	ADMINISTRATIVE & GENERAL		5.00	0 33.02
33.03 MARKETING-EB	A	-3,150	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.03
33.04 MARKETING - A&G	A	-253,238	ADMINISTRATIVE & GENERAL		5.00	0 33.04
33.05 MARKETING-RADIOLOGY	A	-496	OPERATING ROOM		50.00	0 33.05
33.06 BAD DEBT EXPENSE	A	-331,344	ADMINISTRATIVE & GENERAL		5.00	0 33.06
33.07 CHARITABLE CONTRIBUTIONS	A	-7,025	ADMINISTRATIVE & GENERAL		5.00	0 33.07
33.08 MEDICAL RECORDS	B	-18,422	ADMINISTRATIVE & GENERAL		5.00	0 33.08
33.09 REBATES	B	-414	MEDICAL RECORDS & LIBRARY		16.00	0 33.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,178,110				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: 15-0166

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

Worksheet A-8-1

Date/Time Prepared:  
5/30/2017 11:43 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN EXPENSE	179	1,800,000 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	BUILDING CAPITAL COSTS	1,030,027	0 2.00
3.00	0.00			0	0 3.00
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,030,206	1,800,000 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.

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

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

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

6.00	G	MRA	100.00	PINNACLE HOSPITAL	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 15-0166

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

Worksheet A-8-1

Date/Time Prepared:  
5/30/2017 11:43 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	-1,799,821	0		1.00
2.00	1,030,027	9		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-769,794			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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 CARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0166

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

Worksheet A-8-2

Date/Time Prepared:  
5/30/2017 11:43 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	53.00	ANESTHESIOLOGY	215,969	215,969	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	495,475	495,475	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			711,444	711,444	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	53.00	ANESTHESIOLOGY	0	0	0	215,969	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	495,475	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	711,444	200.00



COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0166

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2017 11:43 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,343,358	1,343,358			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,352,154		1,352,154		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	744,163	0	0	744,163	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,520,916	244,079	245,678	188,804	5.00
7.00 00700	OPERATION OF PLANT	722,903	146,371	147,330	4,389	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	7,167	7,214	0	8.00
9.00 00900	HOUSEKEEPING	158,404	0	0	8,083	9.00
10.00 01000	DIETARY	237,231	17,704	17,820	16,727	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
14.00 01400	CENTRAL SERVICES & SUPPLY	456,085	0	0	16,076	14.00
15.00 01500	PHARMACY	452,063	9,009	9,068	39,879	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	300,453	0	0	23,053	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,999,230	277,106	278,920	133,445	30.00
31.00 03100	INTENSIVE CARE UNIT	286,795	0	0	22,830	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	1,850,211	465,761	468,809	129,782	50.00
53.00 05300	ANESTHESIOLOGY	259	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	678,327	111,817	112,549	54,048	54.00
60.00 06000	LABORATORY	281,783	9,840	9,905	0	60.00
65.00 06500	RESPIRATORY THERAPY	380,006	1,752	1,764	29,479	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,024,624	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	8,053,636	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	577,584	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01 09001	URGENT CARE	474,746	52,752	53,097	19,372	90.01
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	27,894,931	1,343,358	1,352,154	685,967	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,563,353	0	0	58,196	192.00
194.00 07950	INDIANA BREAST CENTER	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	29,458,284	1,343,358	1,352,154	744,163	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0166

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

Worksheet B  
Part I  
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	6,199,477				5.00
7.00	00700	OPERATION OF PLANT	272,139	1,293,132			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,833	9,726	27,940		8.00
9.00	00900	HOUSEKEEPING	44,376	0	0	210,863	9.00
10.00	01000	DIETARY	77,159	24,025	0	3,947	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	125,851	0	0	0	14.00
15.00	01500	PHARMACY	135,942	12,226	0	2,009	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	86,228	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	716,654	376,043	27,940	61,784	30.00
31.00	03100	INTENSIVE CARE UNIT	82,528	0	0	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	776,856	632,053	0	103,845	50.00
53.00	05300	ANESTHESIOLOGY	69	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	255,013	151,740	0	24,931	54.00
60.00	06000	LABORATORY	80,370	13,354	0	2,194	60.00
65.00	06500	RESPIRATORY THERAPY	110,083	2,378	0	391	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	539,649	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,146,646	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	153,951	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001	URGENT CARE	159,917	71,587	0	11,762	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,767,264	1,293,132	27,940	210,863	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	432,213	0	0	0	192.00
194.00	07950	INDIANA BREAST CENTER	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,199,477	1,293,132	27,940	210,863	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0166

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2017 11:43 am

Cost Center Description		CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		11.00	14.00	15.00	16.00	19.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	0					11.00
14.00	01400	0	598,012				14.00
15.00	01500	0	0	660,196			15.00
16.00	01600	0	0	0	409,734		16.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	0	0	23,545	0	30.00
31.00	03100	0	0	0	307	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	110,261	0	50.00
53.00	05300	0	0	0	2,067	0	53.00
54.00	05400	0	0	0	31,825	0	54.00
60.00	06000	0	0	0	3,212	0	60.00
65.00	06500	0	0	0	1,839	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	598,012	0	57,077	0	71.00
72.00	07200	0	0	0	162,275	0	72.00
73.00	07300	0	0	660,196	14,691	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001	0	0	0	2,635	0	90.01
92.00	09200	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
114.00	11400	0	598,012	660,196	409,734	0	114.00
118.00		0	598,012	660,196	409,734	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		0	598,012	660,196	409,734	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0166

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

Worksheet B  
Part I  
Date/Time Prepared:  
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
19.00	01900				19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	4,289,280	0	4,289,280	30.00
31.00	03100	392,460	0	392,460	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	4,537,578	0	4,537,578	50.00
53.00	05300	2,395	0	2,395	53.00
54.00	05400	1,420,250	0	1,420,250	54.00
60.00	06000	400,658	0	400,658	60.00
65.00	06500	527,692	0	527,692	65.00
66.00	06600	0	0	0	66.00
67.00	06700	0	0	0	67.00
68.00	06800	0	0	0	68.00
71.00	07100	3,219,362	0	3,219,362	71.00
72.00	07200	10,362,557	0	10,362,557	72.00
73.00	07300	1,406,422	0	1,406,422	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.01	09001	845,868	0	845,868	90.01
92.00	09200		0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
114.00	11400				114.00
118.00		27,404,522	0	27,404,522	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
192.00	19200	2,053,762	0	2,053,762	192.00
194.00	07950	0	0	0	194.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		29,458,284	0	29,458,284	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0166

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2017 11:43 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
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	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	244,079	245,678	489,757	5.00
7.00 00700	OPERATION OF PLANT	0	146,371	147,330	293,701	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	7,167	7,214	14,381	8.00
9.00 00900	HOUSEKEEPING	0	0	0	0	9.00
10.00 01000	DIETARY	0	17,704	17,820	35,524	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	9,009	9,068	18,077	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	277,106	278,920	556,026	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	465,761	468,809	934,570	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	111,817	112,549	224,366	54.00
60.00 06000	LABORATORY	0	9,840	9,905	19,745	60.00
65.00 06500	RESPIRATORY THERAPY	0	1,752	1,764	3,516	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01 09001	URGENT CARE	0	52,752	53,097	105,849	90.01
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,343,358	1,352,154	2,695,512	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	INDIANA BREAST CENTER	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,343,358	1,352,154	2,695,512	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0166		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 5/30/2017 11:43 am	
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>								
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	489,757					5.00
7.00	00700	OPERATION OF PLANT	21,499	315,200				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	303	2,371	17,055			8.00
9.00	00900	HOUSEKEEPING	3,506	0	0	3,506		9.00
10.00	01000	DIETARY	6,096	5,856	0	66	47,542	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,942	0	0	0	0	14.00
15.00	01500	PHARMACY	10,739	2,980	0	33	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,812	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	56,616	91,660	17,055	1,027	47,542	30.00
31.00	03100	INTENSIVE CARE UNIT	6,520	0	0	0	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	61,372	154,062	0	1,727	0	50.00
53.00	05300	ANESTHESIOLOGY	5	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,146	36,987	0	415	0	54.00
60.00	06000	LABORATORY	6,349	3,255	0	36	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,697	580	0	6	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	42,633	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	169,581	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,162	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	URGENT CARE	12,634	17,449	0	196	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	455,612	315,200	17,055	3,506	47,542	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	34,145	0	0	0	0	192.00
194.00	07950	INDIANA BREAST CENTER	0	0	0	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)	489,757	315,200	17,055	3,506	47,542	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/30/2017 11:43 am
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Cost Center Description		CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		11.00	14.00	15.00	16.00	19.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	0					11.00
14.00	01400	0	9,942				14.00
15.00	01500	0	0	31,829			15.00
16.00	01600	0	0	0	6,812		16.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	0	0	393		30.00
31.00	03100	0	0	0	5		31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	1,839		50.00
53.00	05300	0	0	0	34		53.00
54.00	05400	0	0	0	531		54.00
60.00	06000	0	0	0	54		60.00
65.00	06500	0	0	0	31		65.00
66.00	06600	0	0	0	0		66.00
67.00	06700	0	0	0	0		67.00
68.00	06800	0	0	0	0		68.00
71.00	07100	0	9,942	0	952		71.00
72.00	07200	0	0	0	2,684		72.00
73.00	07300	0	0	31,829	245		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001	0	0	0	44		90.01
92.00	09200	0	0	0	0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
114.00	11400	0	0	0	0		114.00
118.00		0	9,942	31,829	6,812	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	0		192.00
194.00	07950	0	0	0	0		194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		0	9,942	31,829	6,812	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0166

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2017 11:43 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
19.00	01900				19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	770,319	0	770,319	30.00
31.00	03100	6,525	0	6,525	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	1,153,570	0	1,153,570	50.00
53.00	05300	39	0	39	53.00
54.00	05400	282,445	0	282,445	54.00
60.00	06000	29,439	0	29,439	60.00
65.00	06500	12,830	0	12,830	65.00
66.00	06600	0	0	0	66.00
67.00	06700	0	0	0	67.00
68.00	06800	0	0	0	68.00
71.00	07100	53,527	0	53,527	71.00
72.00	07200	172,265	0	172,265	72.00
73.00	07300	44,236	0	44,236	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.01	09001	136,172	0	136,172	90.01
92.00	09200		0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
114.00	11400				114.00
118.00		2,661,367	0	2,661,367	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
192.00	19200	34,145	0	34,145	192.00
194.00	07950	0	0	0	194.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		2,695,512	0	2,695,512	202.00



COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0166

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

Worksheet B-1

Date/Time Prepared:  
5/30/2017 11:43 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	59,793				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		59,793			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,161,695		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	10,864	10,864	1,817,033	-6,199,477	5.00
7.00 00700	OPERATION OF PLANT	6,515	6,515	42,240	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	319	319	0	0	8.00
9.00 00900	HOUSEKEEPING	0	0	77,785	0	9.00
10.00 01000	DIETARY	788	788	160,978	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	154,715	0	14.00
15.00 01500	PHARMACY	401	401	383,785	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	221,853	0	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	12,334	12,334	1,284,250	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	219,714	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	20,731	20,731	1,249,001	0	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,977	4,977	520,146	0	54.00
60.00 06000	LABORATORY	438	438	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	78	78	283,696	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01 09001	URGENT CARE	2,348	2,348	186,432	0	90.01
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	59,793	59,793	6,601,628	-6,199,477	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	560,067	0	192.00
194.00 07950	INDIANA BREAST CENTER	0	0	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)	1,343,358	1,352,154	744,163	6,199,477	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	22.466810	22.613918	0.103909	0.266543	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	489,757	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.021057	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0166

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

Worksheet B-1

Date/Time Prepared:  
5/30/2017 11:43 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	42,414					7.00
8.00	00800	319	128,000				8.00
9.00	00900	0	0	42,095			9.00
10.00	01000	788	0	788	100		10.00
11.00	01100	0	0	0	0	0	11.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	401	0	401	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	12,334	128,000	12,334	100	0	30.00
31.00	03100	0	0	0	0	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	20,731	0	20,731	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	4,977	0	4,977	0	0	54.00
60.00	06000	438	0	438	0	0	60.00
65.00	06500	78	0	78	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001	2,348	0	2,348	0	0	90.01
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
114.00	11400						114.00
118.00		42,414	128,000	42,095	100	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		1,293,132	27,940	210,863	394,613	0	202.00
203.00		30.488329	0.218281	5.009217	3,946.130000	0.000000	203.00
204.00		315,200	17,055	3,506	47,542	0	204.00
205.00		7.431508	0.133242	0.083288	475.420000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0166

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		14.00	15.00	16.00	19.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
14.00	01400	100				14.00
15.00	01500	0	100			15.00
16.00	01600	0	0	108,491,950		16.00
19.00	01900	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	0	0	6,233,915	0	30.00
31.00	03100	0	0	81,222	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	0	0	29,192,814	0	50.00
53.00	05300	0	0	547,216	0	53.00
54.00	05400	0	0	8,425,891	0	54.00
60.00	06000	0	0	850,341	0	60.00
65.00	06500	0	0	486,878	0	65.00
66.00	06600	0	0	0	0	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	0	0	0	68.00
71.00	07100	100	0	15,111,619	0	71.00
72.00	07200	0	0	42,974,948	0	72.00
73.00	07300	0	100	3,889,548	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01	09001	0	0	697,558	0	90.01
92.00	09200	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
114.00	11400					114.00
118.00		100	100	108,491,950	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00	19200	0	0	0	0	192.00
194.00	07950	0	0	0	0	194.00
200.00						200.00
201.00						201.00
202.00		598,012	660,196	409,734	0	202.00
203.00		5,980.120000	6,601.960000	0.003777	0.000000	203.00
204.00		9,942	31,829	6,812	0	204.00
205.00		99.420000	318.290000	0.000063	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0166

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

Worksheet C  
Part I  
Date/Time Prepared:  
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE	Total Costs	
					Disallowance		
1.00	2.00	3.00	4.00	5.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	4,289,280		4,289,280	0	4,289,280	30.00
31.00	03100 INTENSIVE CARE UNIT	392,460		392,460	0	392,460	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	4,537,578		4,537,578	0	4,537,578	50.00
53.00	05300 ANESTHESIOLOGY	2,395		2,395	0	2,395	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,420,250		1,420,250	0	1,420,250	54.00
60.00	06000 LABORATORY	400,658		400,658	0	400,658	60.00
65.00	06500 RESPIRATORY THERAPY	527,692	0	527,692	0	527,692	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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3,219,362		3,219,362	0	3,219,362	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10,362,557		10,362,557	0	10,362,557	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,406,422		1,406,422	0	1,406,422	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001 URGENT CARE	845,868		845,868	0	845,868	90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	761,730		761,730		761,730	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
114.00	11400 UTILIZATION REVIEW-SNF						114.00
200.00	Subtotal (see instructions)	28,166,252	0	28,166,252	0	28,166,252	200.00
201.00	Less Observation Beds	761,730		761,730		761,730	201.00
202.00	Total (see instructions)	27,404,522	0	27,404,522	0	27,404,522	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0166

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

Worksheet C  
Part I  
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
		Title XVIII			Hospital	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,351,320		5,351,320		30.00
31.00	03100	INTENSIVE CARE UNIT	81,222		81,222		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,884,814	17,308,000	29,192,814	0.155435	50.00
53.00	05300	ANESTHESIOLOGY	90,421	456,795	547,216	0.004377	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,358,643	7,067,248	8,425,891	0.168558	54.00
60.00	06000	LABORATORY	565,033	285,308	850,341	0.471173	60.00
65.00	06500	RESPIRATORY THERAPY	347,219	139,659	486,878	1.083828	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,071,635	7,039,984	15,111,619	0.213039	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,111,595	2,863,353	42,974,948	0.241130	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,387,150	1,502,398	3,889,548	0.361590	73.00
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	URGENT CARE	30,885	666,673	697,558	1.212613	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	36,992	845,603	882,595	0.863057	92.00
SPECIAL PURPOSE COST CENTERS							
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (see instructions)	70,316,929	38,175,021	108,491,950		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	70,316,929	38,175,021	108,491,950		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/30/2017 11:43 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.155435		50.00
53.00	05300 ANESTHESIOLOGY	0.004377		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168558		54.00
60.00	06000 LABORATORY	0.471173		60.00
65.00	06500 RESPIRATORY THERAPY	1.083828		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.213039		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.241130		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.361590		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.01	09001 URGENT CARE	1.212613		90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.863057		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
114.00	11400 UTILIZATION REVIEW-SNF			114.00
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: 15-0166

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

Worksheet C  
Part I  
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	4,289,280		4,289,280	0	4,289,280	30.00
31.00	03100 INTENSIVE CARE UNIT	392,460		392,460	0	392,460	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	4,537,578		4,537,578	0	4,537,578	50.00
53.00	05300 ANESTHESIOLOGY	2,395		2,395	0	2,395	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,420,250		1,420,250	0	1,420,250	54.00
60.00	06000 LABORATORY	400,658		400,658	0	400,658	60.00
65.00	06500 RESPIRATORY THERAPY	527,692	0	527,692	0	527,692	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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3,219,362		3,219,362	0	3,219,362	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10,362,557		10,362,557	0	10,362,557	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,406,422		1,406,422	0	1,406,422	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001 URGENT CARE	845,868		845,868	0	845,868	90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	761,730		761,730		761,730	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
114.00	11400 UTILIZATION REVIEW-SNF						114.00
200.00	Subtotal (see instructions)	28,166,252	0	28,166,252	0	28,166,252	200.00
201.00	Less Observation Beds	761,730		761,730		761,730	201.00
202.00	Total (see instructions)	27,404,522	0	27,404,522	0	27,404,522	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0166

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

Worksheet C  
Part I  
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		Title XIX			Hospital	PPS		
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	5,351,320		5,351,320			30.00
31.00	03100	INTENSIVE CARE UNIT	81,222		81,222			31.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	11,884,814	17,308,000	29,192,814	0.155435	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	90,421	456,795	547,216	0.004377	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,358,643	7,067,248	8,425,891	0.168558	0.000000	54.00
60.00	06000	LABORATORY	565,033	285,308	850,341	0.471173	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	347,219	139,659	486,878	1.083828	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,071,635	7,039,984	15,111,619	0.213039	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,111,595	2,863,353	42,974,948	0.241130	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,387,150	1,502,398	3,889,548	0.361590	0.000000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	URGENT CARE	30,885	666,673	697,558	1.212613	0.000000	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	36,992	845,603	882,595	0.863057	0.000000	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	70,316,929	38,175,021	108,491,950			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	70,316,929	38,175,021	108,491,950			202.00



COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/30/2017 11:43 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital PPS
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.155435		50.00
53.00	05300 ANESTHESIOLOGY	0.004377		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168558		54.00
60.00	06000 LABORATORY	0.471173		60.00
65.00	06500 RESPIRATORY THERAPY	1.083828		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.213039		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.241130		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.361590		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.01	09001 URGENT CARE	1.212613		90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.863057		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
114.00	11400 UTILIZATION REVIEW-SNF			114.00
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: 15-0166

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

Worksheet C Part II Date/Time Prepared: 5/30/2017 11:43 am

Cost Center Description		Title XIX			Hospital	PPS		
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,537,578	1,153,570	3,384,008	0	0	50.00
53.00	05300	ANESTHESIOLOGY	2,395	39	2,356	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,420,250	282,445	1,137,805	0	0	54.00
60.00	06000	LABORATORY	400,658	29,439	371,219	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	527,692	12,830	514,862	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,219,362	53,527	3,165,835	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,362,557	172,265	10,190,292	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,406,422	44,236	1,362,186	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	URGENT CARE	845,868	136,172	709,696	0	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	761,730	136,801	624,929	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (sum of lines 50 thru 199)	23,484,512	2,021,324	21,463,188	0	0	200.00
201.00		Less Observation Beds	761,730	136,801	624,929	0	0	201.00
202.00		Total (line 200 minus line 201)	22,722,782	1,884,523	20,838,259	0	0	202.00

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

Provider CCN: 15-0166

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

Worksheet C  
Part II  
Date/Time Prepared:  
5/30/2017 11:43 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	4,537,578	29,192,814	0.155435	50.00
53.00	05300 ANESTHESIOLOGY	2,395	547,216	0.004377	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,420,250	8,425,891	0.168558	54.00
60.00	06000 LABORATORY	400,658	850,341	0.471173	60.00
65.00	06500 RESPIRATORY THERAPY	527,692	486,878	1.083828	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3,219,362	15,111,619	0.213039	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10,362,557	42,974,948	0.241130	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,406,422	3,889,548	0.361590	73.00
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 URGENT CARE	845,868	697,558	1.212613	90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	761,730	882,595	0.863057	92.00
SPECIAL PURPOSE COST CENTERS					
114.00	11400 UTILIZATION REVIEW-SNF				114.00
200.00	Subtotal (sum of lines 50 thru 199)	23,484,512	103,059,408		200.00
201.00	Less Observation Beds	761,730	0		201.00
202.00	Total (line 200 minus line 201)	22,722,782	103,059,408		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0166		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part I Date/Time Prepared: 5/30/2017 11:43 am		
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	PPS Per Diem (col. 3 / col. 4)		
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00		
30.00	ADULTS & PEDIATRICS	770,319	0	770,319	3,418	225.37	30.00	
31.00	INTENSIVE CARE UNIT	6,525		6,525	36	181.25	31.00	
200.00	Total (Lines 30-199)	776,844		776,844	3,454		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00					
30.00	ADULTS & PEDIATRICS	1,150	259,176					30.00
31.00	INTENSIVE CARE UNIT	6	1,088					31.00
200.00	Total (Lines 30-199)	1,156	260,264					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 5/30/2017 11:43 am
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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	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,153,570	29,192,814	0.039516	3,713,538	146,744	50.00
53.00	05300 ANESTHESIOLOGY	39	547,216	0.000071	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	282,445	8,425,891	0.033521	630,192	21,125	54.00
60.00	06000 LABORATORY	29,439	850,341	0.034620	331,121	11,463	60.00
65.00	06500 RESPIRATORY THERAPY	12,830	486,878	0.026352	139,251	3,670	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0.000000	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	53,527	15,111,619	0.003542	2,710,374	9,600	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	172,265	42,974,948	0.004008	13,376,739	53,614	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	44,236	3,889,548	0.011373	975,907	11,099	73.00
OUTPATIENT SERVICE COST CENTERS							
90.01	09001 URGENT CARE	136,172	697,558	0.195212	12,790	2,497	90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	136,801	882,595	0.154999	36,951	5,727	92.00
200.00	Total (lines 50-199)	2,021,324	103,059,408		21,926,863	265,539	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0166		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part III Date/Time Prepared: 5/30/2017 11:43 am	
Cost Center Description			Title XVIII		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,418	0.00	1,150	0		30.00
31.00	03100	INTENSIVE CARE UNIT	36	0.00	6	0		31.00
200.00		Total (lines 30-199)	3,454		1,156	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/30/2017 11:43 am
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Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	URGENT CARE	0	0	0	0	0	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/30/2017 11:43 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
Title XVIII								
Hospital								
PPS								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	29,192,814	0.000000	0.000000	3,713,538	50.00
53.00	05300	ANESTHESIOLOGY	0	547,216	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,425,891	0.000000	0.000000	630,192	54.00
60.00	06000	LABORATORY	0	850,341	0.000000	0.000000	331,121	60.00
65.00	06500	RESPIRATORY THERAPY	0	486,878	0.000000	0.000000	139,251	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,111,619	0.000000	0.000000	2,710,374	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	42,974,948	0.000000	0.000000	13,376,739	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,889,548	0.000000	0.000000	975,907	73.00
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	URGENT CARE	0	697,558	0.000000	0.000000	12,790	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	882,595	0.000000	0.000000	36,951	92.00
200.00		Total (lines 50-199)	0	103,059,408			21,926,863	200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/30/2017 11:43 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	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	3,875,054	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	2,020,336	0	54.00
60.00	06000 LABORATORY	0	170,046	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	24,987	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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,129,240	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,030,624	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	360,351	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.01	09001 URGENT CARE	0	66,141	0	90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	203,554	0	92.00
200.00	Total (lines 50-199)	0	8,880,333	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/30/2017 11:43 am
Title XVIII		Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.155435	3,875,054	0	0	602,319	50.00
53.00	05300	ANESTHESIOLOGY	0.004377	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168558	2,020,336	0	204	340,544	54.00
60.00	06000	LABORATORY	0.471173	170,046	0	0	80,121	60.00
65.00	06500	RESPIRATORY THERAPY	1.083828	24,987	0	0	27,082	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.213039	1,129,240	0	0	240,572	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.241130	1,030,624	0	0	248,514	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.361590	360,351	0	1,368	130,299	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	URGENT CARE	1.212613	66,141	0	0	80,203	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.863057	203,554	0	0	175,679	92.00
200.00		Subtotal (see instructions)		8,880,333	0	1,572	1,925,333	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		8,880,333	0	1,572	1,925,333	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/30/2017 11:43 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	34	54.00
60.00	06000 LABORATORY	0	0	60.00
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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	495	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.01	09001 URGENT CARE	0	0	90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Subtotal (see instructions)	0	529	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	529	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0166		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part I Date/Time Prepared: 5/30/2017 11:43 am		
Cost Center Description		Title XIX		Hospital		PPS		
		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	770,319	0	770,319	3,418	225.37	30.00	
31.00	INTENSIVE CARE UNIT	6,525		6,525	36	181.25	31.00	
200.00	Total (Lines 30-199)	776,844		776,844	3,454		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	13	2,930					30.00
31.00	INTENSIVE CARE UNIT	0	0					31.00
200.00	Total (Lines 30-199)	13	2,930					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 5/30/2017 11:43 am
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,153,570	29,192,814	0.039516	169,726	6,707	50.00
53.00	05300	ANESTHESIOLOGY	39	547,216	0.000071	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	282,445	8,425,891	0.033521	5,284	177	54.00
60.00	06000	LABORATORY	29,439	850,341	0.034620	3,886	135	60.00
65.00	06500	RESPIRATORY THERAPY	12,830	486,878	0.026352	4,885	129	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	53,527	15,111,619	0.003542	2,995	11	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	172,265	42,974,948	0.004008	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,236	3,889,548	0.011373	13,911	158	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	URGENT CARE	136,172	697,558	0.195212	0	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	136,801	882,595	0.154999	0	0	92.00
200.00		Total (lines 50-199)	2,021,324	103,059,408		200,687	7,317	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0166		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part III Date/Time Prepared: 5/30/2017 11:43 am	
Cost Center Description			Title XIX			Hospital		PPS
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,418	0.00	13	0		30.00
31.00	03100	INTENSIVE CARE UNIT	36	0.00	0	0		31.00
200.00		Total (lines 30-199)	3,454		13	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/30/2017 11:43 am
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Cost Center Description	Title XIX			Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001	URGENT CARE	0	0	0	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0166

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2017 11:43 am

Cost Center Description		Title XIX			Hospital		PPS	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	29,192,814	0.000000	0.000000	169,726	50.00
53.00	05300	ANESTHESIOLOGY	0	547,216	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,425,891	0.000000	0.000000	5,284	54.00
60.00	06000	LABORATORY	0	850,341	0.000000	0.000000	3,886	60.00
65.00	06500	RESPIRATORY THERAPY	0	486,878	0.000000	0.000000	4,885	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,111,619	0.000000	0.000000	2,995	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	42,974,948	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,889,548	0.000000	0.000000	13,911	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	URGENT CARE	0	697,558	0.000000	0.000000	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	882,595	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	103,059,408			200,687	200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/30/2017 11:43 am
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Cost Center Description		Title XIX			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01	09001 URGENT CARE	0	0	0		90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/30/2017 11:43 am
	Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.155435	0	663,857	0	0
53.00 05300 ANESTHESIOLOGY	0.004377	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.168558	0	93,125	0	0
60.00 06000 LABORATORY	0.471173	0	7,413	0	0
65.00 06500 RESPIRATORY THERAPY	1.083828	0	4,003	0	0
66.00 06600 PHYSICAL THERAPY	0.000000	0	0	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.213039	0	53,166	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.241130	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.361590	0	29,311	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.01 09001 URGENT CARE	1.212613	0	4,500	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.863057	0	0	0	0
200.00 Subtotal (see instructions)		0	855,375	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 +/- line 201)		0	855,375	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/30/2017 11:43 am
		Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	103,187	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	15,697	0	54.00
60.00	06000 LABORATORY	3,493	0	60.00
65.00	06500 RESPIRATORY THERAPY	4,339	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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11,326	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	10,599	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.01	09001 URGENT CARE	5,457	0	90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Subtotal (see instructions)	154,098	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	154,098	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2017 11:43 am
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,418	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,418	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)		2,811	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,150	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,289,280	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,289,280	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,289,280	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,254.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,443,147	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)		1,443,147	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0166		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
Title XVIII			Hospital		PPS			
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
			1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT			392,460	36	10,901.67	6	65,410
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)							5,193,603
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)							6,702,160
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)							260,264
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							265,539
52.00	Total Program excludable cost (sum of lines 50 and 51)							525,803
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							6,176,357
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges							0
55.00	Target amount per discharge							0.00
56.00	Target amount (line 54 x line 55)							0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							0
58.00	Bonus payment (see instructions)							0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							0.00
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
62.00	Relief payment (see instructions)							0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)							0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							0
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)							607
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)							1,254.91
89.00	Observation bed cost (line 87 x line 88) (see instructions)							761,730

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0166		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/30/2017 11:43 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	770,319	4,289,280	0.179592	761,730	136,801	90.00
91.00	Nursing School cost	0	4,289,280	0.000000	761,730	0	91.00
92.00	Allied health cost	0	4,289,280	0.000000	761,730	0	92.00
93.00	All other Medical Education	0	4,289,280	0.000000	761,730	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/30/2017 11:43 am
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,418	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,418	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)		2,811	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)		13	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,289,280	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,289,280	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,289,280	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,254.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		16,314	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)		16,314	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0166		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
Title XIX			Hospital		PPS			
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
			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			392,460	36	10,901.67	0	0
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)							40,065
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)							56,379
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)							2,930
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							7,317
52.00	Total Program excludable cost (sum of lines 50 and 51)							10,247
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							46,132
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges							0
55.00	Target amount per discharge							0.00
56.00	Target amount (line 54 x line 55)							0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							0
58.00	Bonus payment (see instructions)							0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							0.00
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
62.00	Relief payment (see instructions)							0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)							0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							0
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)							607
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)							1,254.91
89.00	Observation bed cost (line 87 x line 88) (see instructions)							761,730



COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0166		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/30/2017 11:43 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	770,319	4,289,280	0.179592	761,730	136,801	90.00
91.00	Nursing School cost	0	4,289,280	0.000000	761,730	0	91.00
92.00	Allied health cost	0	4,289,280	0.000000	761,730	0	92.00
93.00	All other Medical Education	0	4,289,280	0.000000	761,730	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/30/2017 11:43 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		2,217,123	30.00
31.00	03100	INTENSIVE CARE UNIT		22,836	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.155435	3,713,538	577,214 50.00
53.00	05300	ANESTHESIOLOGY	0.004377	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168558	630,192	106,224 54.00
60.00	06000	LABORATORY	0.471173	331,121	156,015 60.00
65.00	06500	RESPIRATORY THERAPY	1.083828	139,251	150,924 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.213039	2,710,374	577,415 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.241130	13,376,739	3,225,533 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.361590	975,907	352,878 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.01	09001	URGENT CARE	1.212613	12,790	15,509 90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.863057	36,951	31,891 92.00
200.00		Total (sum of lines 50-94 and 96-98)		21,926,863	5,193,603 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		21,926,863	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/30/2017 11:43 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		5,717	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.155435	169,726	50.00
53.00	05300	ANESTHESIOLOGY	0.004377	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168558	5,284	54.00
60.00	06000	LABORATORY	0.471173	3,886	60.00
65.00	06500	RESPIRATORY THERAPY	1.083828	4,885	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.213039	2,995	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.241130	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.361590	13,911	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.01	09001	URGENT CARE	1.212613	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.863057	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		200,687	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)		200,687	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/30/2017 11:43 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,021,114	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		673,704	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		2,268,767	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		15.81	4.00
<b>Indirect Medical Education Adjustment</b>				
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
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
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
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/30/2017 11:43 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>Uncompensated Care Adjustment</b>				
35.00	Total uncompensated care amount (see instructions)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000001562	0.000001959	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0	0	36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	4,963,585		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
				<b>Amount</b>
				<b>1.00</b>
49.00	Total payment for inpatient operating costs (see instructions)		4,963,585	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		497,094	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
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		5,460,679	59.00
60.00	Primary payer payments		2,988	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		5,457,691	61.00
62.00	Deductibles billed to program beneficiaries		292,188	62.00
63.00	Coinurance billed to program beneficiaries		315	63.00
64.00	Allowable bad debts (see instructions)		0	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		0	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		5,165,188	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-3,027	70.93
70.94	HRR adjustment amount (see instructions)		-32,802	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/30/2017 11:43 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			5,129,359	71.00
71.01	Sequestration adjustment (see instructions)			102,587	71.01
72.00	Interim payments			5,026,772	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)			0	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
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	
<b>HSP Bonus Payment Amount</b>					
100.00	HSP bonus amount (see instructions)			0	100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
<b>HRR Adjustment for HSP Bonus Payment</b>					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0166

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/30/2017 11:43 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,021,114	0	2,021,114		2,021,114	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	673,704	0		2,694,818	2,694,818	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	2,268,767	0	0	2,268,767	2,268,767	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,963,585	0	2,021,114	2,942,471	4,963,585	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,963,585	0	2,021,114	2,942,471	4,963,585	15.00
16.00	Payment for inpatient program capital	50.00	497,094	0	0	497,094	497,094	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0166

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/30/2017 11:43 am

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
19.00	SUBTOTAL		0	2,021,114	3,439,565	5,460,679	19.00	
	W/S L, line	(Amounts from L)						
	0	1.00	2.00	3.00	4.00	5.00		
20.00	Capital DRG other than outlier	1.00	217,436	0	0	217,436	20.00	
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01	
21.00	Capital DRG outlier payments	2.00	279,658	0	0	279,658	21.00	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	497,094	0	0	497,094	26.00	
	W/S E, Part A line	(Amounts to E, Part A)						
	0	1.00	2.00	3.00	4.00	5.00		
27.00	Low volume adjustment factor			0.238393	0.233750		27.00	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96		481,819		481,819	28.00	
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97			803,998	803,998	29.00	
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				100.00	



		Title XVIII			Hospital	PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,021,114	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	673,704		2,694,818	2,694,818	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	2,268,767	0	2,268,767	2,268,767	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,963,585	0	4,963,585	4,963,585	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,963,585	0	4,963,585	4,963,585	15.00
16.00	Payment for inpatient program capital	50.00	497,094	209,169	287,925	497,094	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	<b>SUBTOTAL</b>			209,169	5,251,510	5,460,679	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2017 11:43 am
		Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	217,436	0	217,436	217,436	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	279,658	209,169	70,489	279,658	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	497,094	209,169	287,925	497,094	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-3,027	0	-3,027	-3,027	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-32,802	0	-32,802	-32,802	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/30/2017 11:43 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		529	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,925,333	2.00
3.00	PPS payments		1,586,016	3.00
4.00	Outlier payment (see instructions)		28,360	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)		529	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		1,572	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)		1,572	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,572	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,043	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)		529	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)		1,614,376	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)		336,374	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,278,531	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,278,531	30.00
31.00	Primary payer payments		1,498	31.00
32.00	Subtotal (line 30 minus line 31)		1,277,033	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,277,033	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-12	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,277,045	40.00
40.01	Sequestration adjustment (see instructions)		25,541	40.01
41.00	Interim payments		1,251,145	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		359	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 15-0166

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2017 11:43 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		5,026,772		1,251,145	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)		5,026,772		1,251,145	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		359	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		5,026,772		1,251,504	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

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

Provider CCN: 15-0166

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

Worksheet G

Date/Time Prepared:  
5/30/2017 11:43 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	2,399,770	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	4,337,953	0	0	0	4.00
5.00	Other receivable	26,074	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	728,096	0	0	0	7.00
8.00	Prepaid expenses	280,682	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,772,575	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	25,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	292,424	0	0	0	15.00
16.00	Accumulated depreciation	0	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	15,720,276	0	0	0	23.00
24.00	Accumulated depreciation	-13,983,234	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)	2,054,466	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	9,827,041	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	7,030,993	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,940,882	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,006,700	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	51,676	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,030,251	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	2,452,304	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,452,304	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,482,555	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	-6,655,514				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)	-6,655,514	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	9,827,041	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0166

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

Worksheet G-1

Date/Time Prepared:  
5/30/2017 11:43 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		-8,118,841		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,134,070			2.00
3.00	Total (sum of line 1 and line 2)		-6,984,771		0	3.00
4.00	PRIOR PERIOD ADJUSTMENT	329,257		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		329,257		0	10.00
11.00	Subtotal (line 3 plus line 10)		-6,655,514		0	11.00
12.00		0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-6,655,514		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	PRIOR PERIOD ADJUSTMENT		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			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: 15-0166

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/30/2017 11:43 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	6,423,299		6,423,299	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)	6,423,299		6,423,299	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	81,222		81,222	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)	81,222		81,222	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,504,521		6,504,521	17.00
18.00	Ancillary services	64,741,722	36,649,666	101,391,388	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				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	URGENT CARE	31,457	681,871	713,328	27.00
27.01	PHYSICIANS' PRIVATE OFFICES	0	687,299	687,299	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	71,277,700	38,018,836	109,296,536	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,636,394		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)		31,636,394		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0166

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

Worksheet G-3

Date/Time Prepared:  
5/30/2017 11:43 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	109,296,536	1.00
2.00	Less contractual allowances and discounts on patients' accounts	76,953,156	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,343,380	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,636,394	4.00
5.00	Net income from service to patients (line 3 minus line 4)	706,986	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,055	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	2,648	23.00
24.00	MISC INCOME	421,381	24.00
25.00	Total other income (sum of lines 6-24)	427,084	25.00
26.00	Total (line 5 plus line 25)	1,134,070	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)	1,134,070	29.00



CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0166	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/30/2017 11:43 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		217,436	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		279,658	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)		7.80	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)		497,094	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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)		4.00	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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