

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/26/2016 5:20 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 5/26/2016 Time: 5:20 pm	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN ST ANTHONY-MICHIGAN CITY (150015) 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			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	219,781	149,633	44,034	0	1.00
2.00 Subprovider - IPF	0	18,642	0		0	2.00
3.00 Subprovider - IRF	0	-21,775	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
200.00 Total	0	216,648	149,633	44,034	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 5:19 pm				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 301 W. HOMER ST			PO Box:						1.00	
2.00	City: MICHIGAN CITY			State: IN		Zip Code: 46360		County: LAPORTE		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		FRANCISCAN ST ANTHONY-MICHIGAN CITY	150015	33140	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF		FRANCISCAN ST ANTHONY-MICHIGAN CITY	15S015	33140	4	01/01/1998	N	P	0	4.00
5.00	Subprovider - IRF		FRANCISCAN ST ANTHONY-MICHIGAN CITY	15T015	33140	5	01/01/1997	N	P	0	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)					1		21.00			
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		23.00		
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
			1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		3,213	144	46	51	1,386	68		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.		61	8	0	0	32			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 5:19 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	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	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150015

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

Worksheet S-2
Part I
Date/Time Prepared:
5/26/2016 5:19 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 64.00
		Program Name	Program Code	Unweighted FTEs 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
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	0	76.00
				1.00	2.00	3.00
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N		87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V		XIX			
		1.00		2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N			96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		97.00
Rural Providers							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N					105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N					108.00
		Physical		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.	N	N	N	N		109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.					N	
						1.00	
						2.00	
						3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2					118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	410,296		72,334		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					
119.00	DO NOT USE THIS LINE						
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N			120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y					121.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N					
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.						
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.						
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.						
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.						
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.						
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.						
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.						
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.						
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.						

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 5:19 pm	
		1.00	2.00		
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		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: FRANCISCAN ALLIANCE, INC	Contractor's Name: WISCONSIN PHYSICIAN SERVICES		Contractor's Number: 8001	
142.00	Street: 1515 DRAGOON TRAIL	PO Box:		142.00	
143.00	City: MISHAWAKA	State:		Zip Code: 46546	
				143.00	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y		144.00	
				1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00	
				1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00	
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
				1.00	
Multi campus					
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00	
		Name	County	State	Zip Code
		0	1.00	2.00	3.00
					4.00
					5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)			0.00	
				1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act					
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.50	
		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)	09/01/2015		11/29/2015	
				170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 5:19 pm
			1.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N 171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/26/2016 5:19 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	05/03/2016	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
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		Legal Oper.	
		1.00	2.00	3.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Y/N		Legal Oper.	
		1.00	2.00	3.00	
PS&R Data					
		Description	Part A		Part B
		0	Y/N	Date	Y/N
		1.00	2.00	3.00	
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
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/04/2016		Y
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
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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150015

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

Worksheet S-2
Part II
Date/Time Prepared:
5/26/2016 5:19 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			Y	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	HONG		YANG	41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN ALLIANCE INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(219) 932-2300 X33175		HONG.YANG@FRANCISCANALLIANCE.ORG	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/04/2016	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REGIONAL DIRECTOR REIMBURSEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150015

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2016 5:19 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	
	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	135	49,275	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)		135	49,275	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	14	5,110	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		149	54,385	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	18	6,570		0	16.00
17.00 SUBPROVIDER - IRF	41.00	16	5,840		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		183				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: 150015

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2016 5:19 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,500	3,109	16,588			1.00
2.00 HMO and other (see instructions)	1,334	0				2.00
3.00 HMO IPF Subprovider	40	0				3.00
4.00 HMO IRF Subprovider	121	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)	9,500	3,109	16,588			7.00
8.00 INTENSIVE CARE UNIT	1,315	601	2,779			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		1,130	1,257			13.00
14.00 Total (see instructions)	10,815	4,840	20,624	0.00	725.09	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	796	1,319	2,842	0.00	17.96	16.00
17.00 SUBPROVIDER - IRF	1,992	93	2,740	0.00	20.08	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY		0	0	0.00	0.00	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	763.13	27.00
28.00 Observation Bed Days		721	3,007			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	68	1,372			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: 150015

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2016 5:19 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,658	1,440	6,149	1.00
2.00 HMO and other (see instructions)			286	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	2,658	1,440	6,149	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	100	205	478	16.00
17.00 SUBPROVIDER - IRF	0.00	0	143	7	191	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150015		Period: From 01/01/2015 To 12/31/2015		Worksheet S-3 Part II Date/Time Prepared: 5/26/2016 5:19 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	43,007,428	0	43,007,428	1,587,319.91	27.09	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,690,201	0	3,690,201	141,254.44	26.12	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		738,904	0	738,904	14,587.98	50.65	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		577,439	0	577,439	3,624.95	159.30	13.00
14.00	Home office salaries & wage-related costs		10,046,312	0	10,046,312	250,711.51	40.07	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		13,616,016	0	13,616,016			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,302,340	0	1,302,340			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	899,145	0	899,145	25,626.75	35.09	26.00
27.00	Administrative & General	5.00	4,680,860	0	4,680,860	146,371.46	31.98	27.00
28.00	Administrative & General under contract (see inst.)		72,202	0	72,202	375.87	192.09	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,974,412	0	1,974,412	82,053.37	24.06	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,148,367	0	1,148,367	84,285.36	13.62	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,071,243	-753,526	317,717	20,094.43	15.81	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	753,526	753,526	47,657.62	15.81	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,854,701	0	1,854,701	53,888.79	34.42	38.00
39.00	Central Services and Supply	14.00	84,638	0	84,638	6,849.00	12.36	39.00
40.00	Pharmacy	15.00	1,502,447	0	1,502,447	41,628.77	36.09	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150015

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

Worksheet S-3
Part II
Date/Time Prepared:
5/26/2016 5:19 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
41.00	Medical Records & Medical Records Library	16.00	3,622	0	3,622	161.72	22.40	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150015

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

Worksheet S-3
Part III
Date/Time Prepared:
5/26/2016 5:19 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	43,079,630	0	43,079,630	1,587,695.78	27.13	1.00
2.00	Excluded area salaries (see instructions)	3,690,201	0	3,690,201	141,254.44	26.12	2.00
3.00	Subtotal salaries (line 1 minus line 2)	39,389,429	0	39,389,429	1,446,441.34	27.23	3.00
4.00	Subtotal other wages & related costs (see inst.)	11,362,655	0	11,362,655	268,924.44	42.25	4.00
5.00	Subtotal wage-related costs (see inst.)	13,616,016	0	13,616,016	0.00	34.57	5.00
6.00	Total (sum of lines 3 thru 5)	64,368,100	0	64,368,100	1,715,365.78	37.52	6.00
7.00	Total overhead cost (see instructions)	13,291,637	0	13,291,637	508,993.14	26.11	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part IV Date/Time Prepared: 5/26/2016 5:19 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	654,369	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)	4,178,455	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	6,286,147	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-378	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	26,146	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)	394,221	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	241,833	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	3,088,712	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	48,851	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	14,918,356	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part V Date/Time Prepared: 5/26/2016 5:19 pm
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Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	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: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 5/26/2016 5:19 pm
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				1.00		
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.227870		1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		14,105,596		2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				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		103,731,687		6.00	
7.00	Medicaid cost (line 1 times line 6)		23,637,340		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)		9,531,744		8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone SCHIP		0		9.00	
10.00	Stand-alone SCHIP charges		0		10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00	
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		9,531,744		19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility		13,120,091	20,277,148	33,397,239	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		2,989,675	4,620,554	7,610,229	21.00
22.00	Partial payment by patients approved for charity care		264,300	1,335,100	1,599,400	22.00
23.00	Cost of charity care (line 21 minus line 22)		2,725,375	3,285,454	6,010,829	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)		13,815,085		13,815,085	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		809,787		809,787	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		13,005,298		13,005,298	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,963,517		2,963,517	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		8,974,346		8,974,346	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		18,506,090		18,506,090	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150015

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

Worksheet A
Date/Time Prepared:
5/26/2016 5:19 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT		15,994,855	15,994,855	-7,891,668	8,103,187	1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP		0	0	8,532,140	8,532,140	2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	899,145	13,181,306	14,080,451	-5,303	14,075,148	4.00	
5.00 00500 ADMINI STRATIVE & GENERAL	4,680,860	22,761,088	27,441,948	-9,589	27,432,359	5.00	
7.00 00700 OPERATION OF PLANT	1,974,412	4,104,288	6,078,700	-650	6,078,050	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	0	423,926	423,926	0	423,926	8.00	
9.00 00900 HOUSEKEEPING	1,148,367	316,879	1,465,246	-9,299	1,455,947	9.00	
10.00 01000 DIETARY	1,071,243	631,253	1,702,496	-1,201,045	501,451	10.00	
11.00 01100 CAFETERIA	0	0	0	1,197,557	1,197,557	11.00	
13.00 01300 NURSING ADMINISTRATION	1,854,701	60,081	1,914,782	26	1,914,808	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	84,638	1,352,276	1,436,914	-330,234	1,106,680	14.00	
15.00 01500 PHARMACY	1,502,447	9,376,109	10,878,556	-45,843	10,832,713	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	3,622	1,558,535	1,562,157	0	1,562,157	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	8,926,224	1,385,060	10,311,284	-1,780,785	8,530,499	30.00	
31.00 03100 INTENSIVE CARE UNIT	1,873,966	159,029	2,032,995	-154,711	1,878,284	31.00	
40.00 04000 SUBPROVIDER - I PF	1,033,385	261,492	1,294,877	-6,003	1,288,874	40.00	
41.00 04100 SUBPROVIDER - I RF	866,665	656,352	1,523,017	-29,412	1,493,605	41.00	
43.00 04300 NURSERY	0	0	0	456,044	456,044	43.00	
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
45.00 04500 NURSING FACILITY	0	0	0	0	0	45.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	4,201,122	9,508,377	13,709,499	-7,899,282	5,810,217	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	817,744	817,744	52.00	
53.00 05300 ANESTHESIOLOGY	42,344	40,253	82,597	-718	81,879	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,389,376	935,218	3,324,594	-240,709	3,083,885	54.00	
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	593,011	250,415	843,426	-39,239	804,187	54.01	
55.00 05500 RADIOLOGY-THERAPEUTIC	633,988	1,397,028	2,031,016	-10,363	2,020,653	55.00	
55.01 05501 WOODLAND CANCER CARE CENTER	626,204	424,751	1,050,955	-38,431	1,012,524	55.01	
57.00 05700 CT SCAN	0	0	0	0	0	57.00	
58.00 05800 MRI	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	758,462	2,431,072	3,189,534	-2,157,247	1,032,287	59.00	
60.00 06000 LABORATORY	0	6,051,133	6,051,133	-9,715	6,041,418	60.00	
60.01 06001 FSED LABORATORY	0	1,142,569	1,142,569	-670	1,141,899	60.01	
65.00 06500 RESPIRATORY THERAPY	812,858	192,999	1,005,857	-66,959	938,898	65.00	
66.00 06600 PHYSICAL THERAPY	147,472	2,827,982	2,975,454	-27,258	2,948,196	66.00	
69.00 06900 ELECTROCARDIOLOGY	695,828	185,166	880,994	-24,121	856,873	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,663,715	7,663,715	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,690,988	3,690,988	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.00 03950 CV RESOURCE CENTER	11,644	1,064	12,708	0	12,708	76.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
90.01 09001 OB CLINIC	0	0	0	0	0	90.01	
90.02 09002 PAIN MANAGEMENT	0	0	0	0	0	90.02	
90.03 09003 INFUSION OP SERVICES	207,332	342,827	550,159	-13,164	536,995	90.03	
90.04 09004 MATERNAL HEA	0	0	0	0	0	90.04	
91.00 09100 EMERGENCY	3,068,645	512,235	3,580,880	-260,741	3,320,139	91.00	
91.01 09101 FREE STANDING EMERGENCY DEPT	1,109,316	749,664	1,858,980	-49,881	1,809,099	91.01	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	41,217,277	99,215,282	140,432,559	55,174	140,487,733	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
194.00 07950 RETAIL PHARMACY	0	0	0	0	0	194.00	
194.01 07951 WORKING WELL	1,708,163	822,246	2,530,409	-55,161	2,475,248	194.01	
194.02 07952 APS DUNELAND SURG ASSOC	0	0	0	0	0	194.02	
194.03 07953 MED WATCH	0	-719	-719	0	-719	194.03	
194.04 07954 OCCUPATIONAL MED CENTER	0	0	0	0	0	194.04	
194.05 07955 PHYSICIAN PRACTICE	0	0	0	0	0	194.05	
194.06 07956 DENTAL SERVICES	0	0	0	0	0	194.06	
194.07 07957 DUNELAND MED WATCH	0	0	0	0	0	194.07	
194.08 07958 WESTVILLE CLINIC	0	0	0	0	0	194.08	
194.09 07959 ORTHOPEDICS	0	0	0	0	0	194.09	
194.10 07960 WOMEN SERVICES	0	0	0	0	0	194.10	
194.11 07961 DUNELAND FITNESS CENTER	0	-55	-55	0	-55	194.11	
194.12 07962 CARDIOLOGY ASSOC	0	0	0	0	0	194.12	
194.13 07963 DUNELAND FAMILY PRACTICE	0	0	0	0	0	194.13	
194.14 07964 ORTHOPEDICS	0	0	0	0	0	194.14	
194.15 07965 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.15	
194.16 07966 PHYSICIAN PRACTICE MD WISE	53,100	6,904,878	6,957,978	0	6,957,978	194.16	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150015

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

Worksheet A
Date/Time Prepared:
5/26/2016 5:19 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194.17 07967 ENT	0	0	0	0	0	194.17
194.18 07968 SLEEP CLINIC	0	0	0	0	0	194.18
194.19 07969 HEALTH PARTNERS	0	620	620	-13	607	194.19
194.20 07970 CENTER OF HOPE	28,888	836	29,724	0	29,724	194.20
200.00 TOTAL (SUM OF LINES 118-199)	43,007,428	106,943,088	149,950,516	0	149,950,516	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150015

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

Worksheet A
Date/Time Prepared:
5/26/2016 5:19 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,465,893	5,637,294	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	8,532,140	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,480,950	15,556,098	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,827,252	21,605,107	5.00
7.00	00700	OPERATION OF PLANT	-63,116	6,014,934	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	423,926	8.00
9.00	00900	HOUSEKEEPING	0	1,455,947	9.00
10.00	01000	DIETARY	-65,059	436,392	10.00
11.00	01100	CAFETERIA	-626,226	571,331	11.00
13.00	01300	NURSING ADMINISTRATION	-8,981	1,905,827	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-169,419	937,261	14.00
15.00	01500	PHARMACY	-142,888	10,689,825	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-185,699	1,376,458	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-41,813	8,488,686	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,878,284	31.00
40.00	04000	SUBPROVIDER - I PF	-1,470	1,287,404	40.00
41.00	04100	SUBPROVIDER - I RF	0	1,493,605	41.00
43.00	04300	NURSERY	0	456,044	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-542,546	5,267,671	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	817,744	52.00
53.00	05300	ANESTHESIOLOGY	-2,288	79,591	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-44,736	3,039,149	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0	804,187	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-319,438	1,701,215	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	-30,016	982,508	55.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	-9,820	1,022,467	59.00
60.00	06000	LABORATORY	-23,508	6,017,910	60.00
60.01	06001	FSED LABORATORY	0	1,141,899	60.01
65.00	06500	RESPIRATORY THERAPY	-1,572	937,326	65.00
66.00	06600	PHYSICAL THERAPY	-60,444	2,887,752	66.00
69.00	06900	ELECTROCARDIOLOGY	0	856,873	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-130,465	7,533,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,690,988	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03950	CV RESOURCE CENTER	0	12,708	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OB CLINIC	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	90.02
90.03	09003	INFUSION OP SERVICES	0	536,995	90.03
90.04	09004	MATERNAL HEA	0	0	90.04
91.00	09100	EMERGENCY	-6,250	3,313,889	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	-524,564	1,284,535	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-9,812,513	130,675,220	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	RETAIL PHARMACY	0	0	194.00
194.01	07951	WORKING WELL	0	2,475,248	194.01
194.02	07952	APS DUNELAND SURG ASSOC	0	0	194.02
194.03	07953	MED WATCH	0	-719	194.03
194.04	07954	OCCUPATIONAL MED CENTER	0	0	194.04
194.05	07955	PHYSICIAN PRACTICE	0	0	194.05
194.06	07956	DENTAL SERVICES	0	0	194.06
194.07	07957	DUNELAND MED WATCH	0	0	194.07
194.08	07958	WESTVILLE CLINIC	0	0	194.08
194.09	07959	ORTHOPEDICS	0	0	194.09
194.10	07960	WOMEN SERVICES	0	0	194.10
194.11	07961	DUNELAND FITNESS CENTER	0	-55	194.11
194.12	07962	CARDIOLOGY ASSOC	0	0	194.12
194.13	07963	DUNELAND FAMILY PRACTICE	0	0	194.13
194.14	07964	ORTHOPEDICS	0	0	194.14
194.15	07965	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.15
194.16	07966	PHYSICIAN PRACTICE MD WISE	0	6,957,978	194.16
194.17	07967	ENT	0	0	194.17
194.18	07968	SLEEP CLINIC	0	0	194.18

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150015

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

Worksheet A
Date/Time Prepared:
5/26/2016 5:19 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
194.19	07969 HEALTH PARTNERS	0	607	194.19
194.20	07970 CENTER OF HOPE	0	29,724	194.20
200.00	TOTAL (SUM OF LINES 118-199)	-9,812,513	140,138,003	200.00

RECLASSIFICATIONS

Provider CCN: 150015

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

Worksheet A-6

Date/Time Prepared:
5/26/2016 5:19 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAPITAL						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,532,140	1.00	
	O		0	8,532,140		
B - CAFETERIA						
1.00	CAFETERIA	11.00	753,526	444,031	1.00	
	O		753,526	444,031		
C - WORKER'S COMPENSATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1	1.00	
	O		0	1		
D - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	10,634,219	1.00	
2.00	NURSING ADMINISTRATION	13.00	0	26	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	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
	O		0	10,634,245		
E - MEDICAL SUPPLIES - PACEMAKERS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	720,484	1.00	
2.00		0.00	0	0	2.00	
	O		0	720,484		
F - NURSERY AND LABOR/DELIVERY						
1.00	NURSERY	43.00	382,409	73,635	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	685,707	132,037	2.00	
	O		1,068,116	205,672		
G - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	617,640	1.00	
	O		0	617,640		
H - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	22,832	1.00	
2.00		0.00	0	0	2.00	
	O		0	22,832		
I - IMPLANTABLE DEVICES						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,970,504	1.00	
	O		0	2,970,504		
500.00	Grand Total: Increases		1,821,642	24,147,549	500.00	

RECLASSIFICATIONS

Provider CCN: 150015

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

Worksheet A-6
Date/Time Prepared:
5/26/2016 5:19 pm

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - CAPITAL							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,532,140	9		1.00
	O		0	8,532,140			
B - CAFETERIA							
1.00	DIETARY	10.00	753,526	444,031	0		1.00
	O		753,526	444,031			
C - WORKER'S COMPENSATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1	0		1.00
	O		0	1			
D - MEDICAL SUPPLIES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,304	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	9,588	0		2.00
3.00	OPERATION OF PLANT	7.00	0	650	0		3.00
4.00	HOUSEKEEPING	9.00	0	9,299	0		4.00
5.00	DIETARY	10.00	0	3,488	0		5.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	330,234	0		7.00
8.00	PHARMACY	15.00	0	45,843	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	506,997	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	154,711	0		10.00
11.00	SUBPROVIDER - IPF	40.00	0	6,003	0		11.00
12.00	SUBPROVIDER - IRF	41.00	0	29,412	0		12.00
13.00	OPERATING ROOM	50.00	0	7,258,810	0		13.00
14.00	ANESTHESIOLOGY	53.00	0	718	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	240,709	0		15.00
16.00	FSED RADIOLOGY - DIAGNOSTIC	54.01	0	39,239	0		16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	10,363	0		17.00
18.00	WOODLAND CANCER CARE CENTER	55.01	0	38,431	0		18.00
19.00	CARDIAC CATHETERIZATION	59.00	0	1,436,763	0		19.00
20.00	LABORATORY	60.00	0	9,715	0		20.00
21.00	FSED LABORATORY	60.01	0	670	0		21.00
22.00	RESPIRATORY THERAPY	65.00	0	66,959	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	27,258	0		23.00
24.00	ELECTROCARDIOLOGY	69.00	0	24,121	0		24.00
26.00	INFUSION OP SERVICES	90.03	0	13,164	0		26.00
27.00	EMERGENCY	91.00	0	260,741	0		27.00
28.00	FREE STANDING EMERGENCY DEPT	91.01	0	49,881	0		28.00
29.00	WORKING WELL	194.01	0	55,161	0		29.00
30.00	HEALTH PARTNERS	194.19	0	13	0		30.00
	O		0	10,634,245			
E - MEDICAL SUPPLIES - PACEMAKERS							
1.00		0.00	0	0	0		1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	720,484	0		2.00
	O		0	720,484			
F - NURSERY AND LABOR/DELIVERY							
1.00	ADULTS & PEDIATRICS	30.00	1,068,116	205,672	0		1.00
2.00		0.00	0	0	0		2.00
	O		1,068,116	205,672			
G - DEPRECIATION							
1.00	OPERATING ROOM	50.00	0	617,640	9		1.00
	O		0	617,640			
H - INTEREST							
1.00		0.00	0	0	11		1.00
2.00	OPERATING ROOM	50.00	0	22,832	0		2.00
	O		0	22,832			
I - IMPLANTABLE DEVICES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,970,504	0		1.00
	O		0	2,970,504			
500.00	Grand Total: Decreases		1,821,642	24,147,549			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150015

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

Worksheet A-7
Part I
Date/Time Prepared:
5/26/2016 5:19 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	6,650,028	530,084	0	530,084	0	1.00
2.00	Land Improvements	4,012,783	22,434	0	22,434	0	2.00
3.00	Buildings and Fixtures	92,425,500	382,220	0	382,220	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	4,316,923	0	4,316,923	0	5.00
6.00	Movable Equipment	105,485,388	1,754,921	0	1,754,921	649,741	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	208,573,699	7,006,582	0	7,006,582	649,741	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	208,573,699	7,006,582	0	7,006,582	649,741	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,180,112	0				1.00
2.00	Land Improvements	4,035,217	1,533,892				2.00
3.00	Buildings and Fixtures	92,807,720	12,132,279				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	4,316,923	0				5.00
6.00	Movable Equipment	106,590,568	15,539,329				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	214,930,540	29,205,500				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	214,930,540	29,205,500				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150015

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

Worksheet A-7
Part II
Date/Time Prepared:
5/26/2016 5:19 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	15,994,855	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	15,994,855	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	15,994,855				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	15,994,855				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150015

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

Worksheet A-7
Part III
Date/Time Prepared:
5/26/2016 5:19 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	104,023,049	0	104,023,049	0.483984	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	110,907,490	0	110,907,490	0.516016	0	2.00
3.00	Total (sum of lines 1-2)	214,930,539	0	214,930,539	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	9,783,515	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	8,532,140	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	18,315,655	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	-3,849,830	0	0	-296,391	5,637,294	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	8,532,140	2.00
3.00	Total (sum of lines 1-2)	-3,849,830	0	0	-296,391	14,169,434	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150015

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

Worksheet A-8

Date/Time Prepared:
5/26/2016 5:19 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst. A-7 Ref.			
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)	B	-25,591	0	CAP REL COSTS-BLDG & FIXT	1.00		11	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0	0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-6,950	0	ADMINISTRATIVE & GENERAL	5.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0	0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0	0		0.00		0	7.00
8.00 Television and radio service (chapter 21)		0	0		0.00		0	8.00
9.00 Parking lot (chapter 21)		0	0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,791,710	0		0.00		0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0	0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-258,291	0		0.00		0	12.00
13.00 Laundry and linen service		0	0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-608,158	0	CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others		0	0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0	0		0.00		0	16.00
17.00 Sale of drugs to other than patients		0	0		0.00		0	17.00
18.00 Sale of medical records and abstracts		0	0		0.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0	0		0.00		0	19.00
20.00 Vending machines	B	-18,068	0	CAFETERIA	11.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0	0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0	0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist		0	0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant		0	0	0	0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	*** Cost Center Deleted ***	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)		0	0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0	*** Cost Center Deleted ***	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0	0		0.00		0	32.00
33.00 UNCLAIMED PROPERTY	B	-4,181	0	ADMINISTRATIVE & GENERAL	5.00		0	33.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
33.01 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.01
34.00 ICU CONSULTING FEES	A	1	ADMINISTRATIVE & GENERAL		5.00	0	34.00
35.00 STAFF EDUCATION COSTS	B	-597	ADMINISTRATIVE & GENERAL		5.00	0	35.00
36.00 OB PROGRAM FEES	B	-261	ADULTS & PEDIATRICS		30.00	0	36.00
37.00 DONATIONS EXPENSE	A	-19,325	ADMINISTRATIVE & GENERAL		5.00	0	37.00
38.00 ADVERTISING EXPENSE	A	-859,600	ADMINISTRATIVE & GENERAL		5.00	0	38.00
39.00 RENTAL INCOME	B	-218,984	ADMINISTRATIVE & GENERAL		5.00	0	39.00
40.00 A&G MISC REVENUE	B	-35,704	ADMINISTRATIVE & GENERAL		5.00	0	40.00
41.00 LOBBYING	A	-1,811	ADMINISTRATIVE & GENERAL		5.00	0	41.00
42.00 INTEREST INCOME	B	-1	ADMINISTRATIVE & GENERAL		5.00	0	42.00
43.00 WOODLAND SURGERY BUILDING RENTAL INC	B	-61,354	OPERATION OF PLANT		7.00	0	43.00
44.00 GOODWILL	A	-296,391	CAP REL COSTS-BLDG & FIXT		1.00	14	44.00
45.00 OUTSIDE HOME HEALTH SUPPLIES	A	-3,425	ADMINISTRATIVE & GENERAL		5.00	0	45.00
46.00 ER MISC. INCOME	B	-1	FREE STANDING EMERGENCY DEPT		91.01	0	46.00
47.00 DISCOUNTS/REBATES	B	-65,059	DIETARY		10.00	0	47.00
48.00 DISCOUNTS/REBATES	B	-138,681	PHARMACY		15.00	0	48.00
49.00 HAF PROVIDER TAX	A	-5,413,580	ADMINISTRATIVE & GENERAL		5.00	0	49.00
49.01 PENSION	A	1,485,000	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	49.01
49.02 MEDICAL RECORDS	B	-7,810	ADMINISTRATIVE & GENERAL		5.00	0	49.02
49.03 DISCOUNTS EARNED/REBATES	B	-1,762	OPERATION OF PLANT		7.00	10	49.03
49.04 DISCOUNTS EARNED/REBATES	B	-52,657	OPERATING ROOM		50.00	0	49.04
49.05 DISCOUNTS EARNED/REBATES	B	-199,399	OPERATING ROOM		50.00	0	49.05
49.06 DISCOUNTS EARNED/REBATES	B	-44,736	RADIOLOGY-DIAGNOSTIC		54.00	0	49.06
49.07 RENTAL INCOME	B	-20,121	WOODLAND CANCER CARE CENTER		55.01	0	49.07
49.08 DISCOUNTS EARNED/REBATES	B	-6,360	LABORATORY		60.00	0	49.08
49.09 DISCOUNTS EARNED/REBATES	B	-4,172	RESPIRATORY THERAPY		65.00	0	49.09
49.10 MISCELLANEOUS - OTHER OPERATING	B	-275	PHYSICAL THERAPY		66.00	0	49.10
49.11 DISCOUNTS EARNED/REBATES	B	-75,035	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00	0	49.11
49.12 DISCOUNTS EARNED/REBATES	B	-55,430	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00	0	49.12
49.13 MISCELLANEOUS - OTHER OPERATING	B	-1,100	PHARMACY		15.00	0	49.13
49.14 MISCELLANEOUS - OTHER OPERATING	B	-26	OPERATING ROOM		50.00	0	49.14
49.15 BH WORKSHOP/SPEAKER INC	B	-908	ADMINISTRATIVE & GENERAL		5.00	0	49.15
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,812,513					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: 150015

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

Worksheet A-8-1

Date/Time Prepared: 5/26/2016 5:19 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	1,050,732	4,897,803
2.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOWABLE NEW CAPITAL COSTS	1,703,160	0
3.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	13,166,050	10,923,122
4.00	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICE	0	169,419
4.01	15.00	PHARMACY	COEP / PHARMACY	213,954	216,144
4.02	16.00	MEDICAL RECORDS & LIBRARY	HIM	1,348,183	1,533,882
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			17,482,079	17,740,370

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

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

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

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

6.00	B	100.00	FRANCISCAN ALLI	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: 150015

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

Worksheet A-8-1

Date/Time Prepared:
5/26/2016 5:19 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-3,847,071	11		1.00
2.00	1,703,160	9		2.00
3.00	2,242,928	0		3.00
4.00	-169,419	0		4.00
4.01	-2,190	0		4.01
4.02	-185,699	0		4.02
5.00	-258,291			5.00

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

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

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

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

6.00	HEALTHCARE SERV		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: 150015

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

Worksheet A-8-2

Date/Time Prepared:
5/26/2016 5:19 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTME	4,050	4,050	0	0	0	1.00
2.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	1,579,533	1,468,221	111,312	197,500	866	2.00
3.00	13.00	AGGREGATE-NURSING ADMINISTRATIVE	22,369	7,856	14,513	197,500	141	3.00
4.00	15.00	AGGREGATE-PHARMACY	3,956	0	3,956	197,500	32	4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	55,700	38,575	17,125	197,500	149	5.00
6.00	40.00	AGGREGATE-SUBPROVIDER - IPF	11,250	-1,588	12,838	197,500	103	6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	382,745	209,320	173,425	246,400	779	7.00
8.00	53.00	AGGREGATE-ANESTHESIOLOGY	10,000	0	10,000	239,400	67	8.00
9.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	319,438	319,438	0	0	0	9.00
10.00	55.01	AGGREGATE-WOODLAND CANCER CARE CENTE	27,020	9,895	17,125	271,900	137	10.00
11.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	29,000	3,750	25,250	197,500	202	11.00
12.00	60.00	AGGREGATE-LABORATORY	59,212	0	59,212	197,500	443	12.00
13.00	65.00	AGGREGATE-RESPIRATORY THERAPY	-2,600	-2,600	0	0	0	13.00
14.00	66.00	AGGREGATE-PHYSICAL THERAPY	110,209	0	110,209	197,500	527	14.00
15.00	91.00	AGGREGATE-EMERGENCY	26,000	0	26,000	197,500	208	15.00
16.00	91.01	AGGREGATE-FREE STANDING EMERGENCY DE	531,684	522,372	9,312	197,500	75	16.00
200.00			3,169,566	2,579,289	590,277		3,729	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	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTME	0	0	0	0	0	1.00
2.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	82,228	4,111	0	0	0	2.00
3.00	13.00	AGGREGATE-NURSING ADMINISTRATIVE	13,388	669	0	0	0	3.00
4.00	15.00	AGGREGATE-PHARMACY	3,039	152	0	0	0	4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	14,148	707	0	0	0	5.00
6.00	40.00	AGGREGATE-SUBPROVIDER - IPF	9,780	489	0	0	0	6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	92,281	4,614	0	0	0	7.00
8.00	53.00	AGGREGATE-ANESTHESIOLOGY	7,712	386	0	0	0	8.00
9.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	55.01	AGGREGATE-WOODLAND CANCER CARE CENTE	17,909	895	0	0	0	10.00
11.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	19,180	959	0	0	0	11.00
12.00	60.00	AGGREGATE-LABORATORY	42,064	2,103	0	0	0	12.00
13.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	13.00
14.00	66.00	AGGREGATE-PHYSICAL THERAPY	50,040	2,502	0	0	0	14.00
15.00	91.00	AGGREGATE-EMERGENCY	19,750	988	0	0	0	15.00
16.00	91.01	AGGREGATE-FREE STANDING EMERGENCY DE	7,121	356	0	0	0	16.00
200.00			378,640	18,931	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	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTME	0	0	0	4,050	1.00
2.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	82,228	29,084	1,497,305	2.00
3.00	13.00	AGGREGATE-NURSING ADMINISTRATIVE	0	13,388	1,125	8,981	3.00
4.00	15.00	AGGREGATE-PHARMACY	0	3,039	917	917	4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	14,148	2,977	41,552	5.00
6.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	9,780	3,058	1,470	6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	0	92,281	81,144	290,464	7.00
8.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	7,712	2,288	2,288	8.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150015

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

Worksheet A-8-2

Date/Time Prepared:
5/26/2016 5:19 pm

	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		
9.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	0	0	0	319,438		9.00
10.00	55.01	AGGREGATE-WOODLAND CANCER CARE CENTER	0	17,909	0	9,895		10.00
11.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	19,180	6,070	9,820		11.00
12.00	60.00	AGGREGATE-LABORATORY	0	42,064	17,148	17,148		12.00
13.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	-2,600		13.00
14.00	66.00	AGGREGATE-PHYSICAL THERAPY	0	50,040	60,169	60,169		14.00
15.00	91.00	AGGREGATE-EMERGENCY	0	19,750	6,250	6,250		15.00
16.00	91.01	AGGREGATE-FREE STANDING EMERGENCY DE	0	7,121	2,191	524,563		16.00
200.00			0	378,640	212,421	2,791,710		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150015

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2016 5: 19 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	5,637,294	5,637,294			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	8,532,140		8,532,140		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	15,556,098	54,328	16,871	15,627,297	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	21,605,107	813,318	1,016,030	1,737,170	5.00
7.00 00700	OPERATION OF PLANT	6,014,934	709,398	1,012,744	732,748	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	423,926	62,631	167	0	8.00
9.00 00900	HOUSEKEEPING	1,455,947	102,826	38,407	426,184	9.00
10.00 01000	DIETARY	436,392	44,871	23,318	117,912	10.00
11.00 01100	CAFETERIA	571,331	106,423	0	279,650	11.00
13.00 01300	NURSING ADMINISTRATION	1,905,827	25,583	254,589	688,320	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	937,261	98,945	104,979	31,411	14.00
15.00 01500	PHARMACY	10,689,825	47,329	3,754	557,591	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,376,458	43,822	13,297	1,344	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	8,488,686	984,937	124,550	2,916,305	30.00
31.00 03100	INTENSIVE CARE UNIT	1,878,284	88,379	165,850	695,470	31.00
40.00 04000	SUBPROVIDER - I PF	1,287,404	93,819	6,378	383,512	40.00
41.00 04100	SUBPROVIDER - I RF	1,493,605	169,803	39,144	321,638	41.00
43.00 04300	NURSERY	456,044	13,473	330	141,920	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,267,671	283,420	1,513,469	1,559,129	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	817,744	108,087	0	254,481	52.00
53.00 05300	ANESTHESIOLOGY	79,591	8,183	10,340	15,715	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,039,149	271,401	823,478	886,750	54.00
54.01 05401	FSED RADIOLOGY - DIAGNOSTIC	804,187	42,938	381,509	220,079	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	1,701,215	134,224	16,377	235,287	55.00
55.01 05501	WOODLAND CANCER CARE CENTER	982,508	160,152	1,258,988	232,398	55.01
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,022,467	64,909	566,314	281,482	59.00
60.00 06000	LABORATORY	6,017,910	134,569	9,643	0	60.00
60.01 06001	FSED LABORATORY	1,141,899	19,483	155	0	60.01
65.00 06500	RESPIRATORY THERAPY	937,326	30,019	23,091	301,669	65.00
66.00 06600	PHYSICAL THERAPY	2,887,752	20,682	6,377	54,730	66.00
69.00 06900	ELECTROCARDIOLOGY	856,873	82,938	77,476	258,237	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,533,250	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	3,690,988	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03950	CV RESOURCE CENTER	12,708	0	0	4,321	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	OB CLINIC	0	0	0	0	90.01
90.02 09002	PAIN MANAGEMENT	0	0	0	0	90.02
90.03 09003	INFUSION OP SERVICES	536,995	20,877	519	76,945	90.03
90.04 09004	MATERNAL HEA	0	0	0	0	90.04
91.00 09100	EMERGENCY	3,313,889	301,120	118,423	1,138,842	91.00
91.01 09101	FREE STANDING EMERGENCY DEPT	1,284,535	320,438	667,045	411,692	91.01
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	130,675,220	5,463,325	8,293,612	14,962,932	129,598,358
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,762	0	0	190.00
194.00 07950	RETAIL PHARMACY	0	0	0	0	194.00
194.01 07951	WORKING WELL	2,475,248	0	183,165	633,937	194.01
194.02 07952	APS DUNELAND SURG ASSOC	0	0	0	0	194.02
194.03 07953	MED WATCH	-719	91,121	0	0	194.03
194.04 07954	OCCUPATIONAL MED CENTER	0	0	0	0	194.04
194.05 07955	PHYSICIAN PRACTICE	0	0	0	0	194.05
194.06 07956	DENTAL SERVICES	0	0	0	0	194.06
194.07 07957	DUNELAND MED WATCH	0	0	0	0	194.07
194.08 07958	WESTVILLE CLNIC	0	0	0	0	194.08
194.09 07959	ORTHOPEDICS	0	0	0	0	194.09
194.10 07960	WOMEN SERVICES	0	68,086	0	0	194.10
194.11 07961	DUNELAND FITNESS CENTER	-55	0	34,086	0	194.11
194.12 07962	CARDIOLOGY ASSOC	0	0	0	0	194.12
194.13 07963	DUNELAND FAMILY PRACTICE	0	0	0	0	194.13

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150015

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2016 5:19 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
194.14 07964 ORTHOPEDICS	0	0	0	0	0	194.14
194.15 07965 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.15
194.16 07966 PHYSICIAN PRACTICE MD WISE	6,957,978	0	11,242	19,707	6,988,927	194.16
194.17 07967 ENT	0	0	0	0	0	194.17
194.18 07968 SLEEP CLINIC	0	0	0	0	0	194.18
194.19 07969 HEALTH PARTNERS	607	0	10,035	0	10,642	194.19
194.20 07970 CENTER OF HOPE	29,724	0	0	10,721	40,445	194.20
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	140,138,003	5,637,294	8,532,140	15,627,297	140,138,003	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150015

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2016 5:19 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,171,625				5.00
7.00	00700	OPERATION OF PLANT	1,854,451	10,324,275			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	106,567	159,256	752,547		8.00
9.00	00900	HOUSEKEEPING	443,012	261,463	0	2,727,839	9.00
10.00	01000	DIETARY	136,294	114,097	301	31,427	904,612
11.00	01100	CAFETERIA	209,622	270,609	0	74,537	0
13.00	01300	NURSING ADMINISTRATION	629,326	65,051	0	17,918	0
14.00	01400	CENTRAL SERVICES & SUPPLY	256,738	251,593	0	69,299	0
15.00	01500	PHARMACY	2,473,784	120,347	0	33,148	0
16.00	01600	MEDICAL RECORDS & LIBRARY	314,173	111,430	0	30,692	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,739,988	2,504,463	353,697	689,831	589,127
31.00	03100	INTENSIVE CARE UNIT	619,181	224,727	37,627	61,899	91,157
40.00	04000	SUBPROVIDER - I/PF	387,782	238,560	82,780	65,709	93,225
41.00	04100	SUBPROVIDER - I/RF	443,192	431,771	30,102	118,927	89,874
43.00	04300	NURSERY	133,945	34,260	226	9,436	41,229
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,888,139	720,672	39,885	198,502	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	258,427	274,839	0	75,702	0
53.00	05300	ANESTHESIOLOGY	24,923	20,807	0	5,731	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,099,289	690,109	30,252	190,084	0
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	317,193	109,181	0	30,073	0
55.00	05500	RADIOLOGY-THERAPEUTIC	456,967	341,301	376	94,008	0
55.01	05501	WOODLAND CANCER CARE CENTER	576,719	407,229	7,526	112,167	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	423,702	165,048	226	45,461	0
60.00	06000	LABORATORY	1,349,184	342,177	0	94,249	0
60.01	06001	FSED LABORATORY	254,316	49,541	0	13,646	0
65.00	06500	RESPIRATORY THERAPY	282,904	76,332	0	21,025	0
66.00	06600	PHYSICAL THERAPY	650,175	52,590	22,576	14,485	0
69.00	06900	ELECTROCARDIOLOGY	279,273	210,893	3,763	58,088	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,649,390	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	808,134	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03950	CV RESOURCE CENTER	3,728	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	OB CLINIC	0	0	0	0	0
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0
90.03	09003	INFUSION OP SERVICES	139,106	53,085	226	14,622	0
90.04	09004	MATERNAL HEA	0	0	0	0	0
91.00	09100	EMERGENCY	1,066,775	765,679	75,255	210,899	0
91.01	09101	FREE STANDING EMERGENCY DEPT	587,593	814,801	30,102	224,429	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,863,992	9,881,911	714,920	2,605,994	904,612
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,232	37,537	0	10,339	0
194.00	07950	RETAIL PHARMACY	0	0	0	0	0
194.01	07951	WORKING WELL	720,853	0	0	0	0
194.02	07952	APS DUNELAND SURG ASSOC	0	0	0	0	0
194.03	07953	MED WATCH	19,793	231,700	0	63,820	0
194.04	07954	OCCUPATIONAL MED CENTER	0	0	0	0	0
194.05	07955	PHYSICIAN PRACTICE	0	0	0	0	0
194.06	07956	DENTAL SERVICES	0	0	0	0	0
194.07	07957	DUNELAND MED WATCH	0	0	0	0	0
194.08	07958	WESTVILLE CLINIC	0	0	0	0	0
194.09	07959	ORTHOPEDICS	0	0	0	0	0
194.10	07960	WOMEN SERVICES	14,907	173,127	0	47,686	0
194.11	07961	DUNELAND FITNESS CENTER	7,451	0	0	0	0
194.12	07962	CARDIOLOGY ASSOC	0	0	0	0	0
194.13	07963	DUNELAND FAMILY PRACTICE	0	0	0	0	0
194.14	07964	ORTHOPEDICS	0	0	0	0	0
194.15	07965	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.16	07966	PHYSICIAN PRACTICE MD WISE	1,530,212	0	0	0	0
194.17	07967	ENT	0	0	0	0	0
194.18	07968	SLEEP CLINIC	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150015

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

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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	
194.19	07969 HEALTH PARTNERS	2,330	0	37,627	0	0	194.19
194.20	07970 CENTER OF HOPE	8,855	0	0	0	0	194.20
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	25,171,625	10,324,275	752,547	2,727,839	904,612	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150015		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part I Date/Time Prepared: 5/26/2016 5:19 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						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	1,512,172					11.00
13.00	01300	71,072	3,657,686				13.00
14.00	01400	9,025	0	1,759,251			14.00
15.00	01500	54,888	0	0	13,980,666		15.00
16.00	01600	1,372	0	0	0	1,892,588	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	381,087	1,319,604	0	0	116,681	30.00
31.00	03100	70,057	319,344	0	0	19,388	31.00
40.00	04000	49,265	104,608	0	0	12,275	40.00
41.00	04100	55,080	126,689	0	0	22,868	41.00
43.00	04300	0	0	0	0	4,382	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	210,444	647,244	0	0	364,527	50.00
52.00	05200	0	0	0	0	7,857	52.00
53.00	05300	2,853	0	0	0	15,165	53.00
54.00	05400	106,813	0	0	0	249,963	54.00
54.01	05401	25,702	0	0	0	51,435	54.01
55.00	05500	21,423	0	0	0	38,637	55.00
55.01	05501	25,757	0	0	0	7,424	55.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	26,854	198,451	0	0	56,754	59.00
60.00	06000	0	0	0	0	163,770	60.00
60.01	06001	0	0	0	0	19,304	60.01
65.00	06500	39,390	0	0	0	40,547	65.00
66.00	06600	73,732	0	0	0	56,016	66.00
69.00	06900	30,996	28,981	0	0	46,779	69.00
71.00	07100	0	0	1,267,832	0	57,131	71.00
72.00	07200	0	0	491,419	0	44,782	72.00
73.00	07300	0	0	0	13,980,666	304,824	73.00
76.00	03950	411	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	8,558	75,075	0	0	8,885	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	125,932	686,989	0	0	149,642	91.00
91.01	09101	39,554	0	0	0	33,552	91.01
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		1,430,265	3,506,985	1,759,251	13,980,666	1,892,588	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	78,121	148,217	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
194.10	07960	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
194.12	07962	0	0	0	0	0	194.12
194.13	07963	0	0	0	0	0	194.13
194.14	07964	0	0	0	0	0	194.14
194.15	07965	0	0	0	0	0	194.15
194.16	07966	2,469	0	0	0	0	194.16
194.17	07967	0	0	0	0	0	194.17

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150015

Period:
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To 12/31/2015

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
194.18	07968	SLEEP CLINIC	0	0	0	0	0	194.18
194.19	07969	HEALTH PARTNERS	0	0	0	0	0	0
194.20	07970	CENTER OF HOPE	1,317	2,484	0	0	0	0
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,512,172	3,657,686	1,759,251	13,980,666	1,892,588	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150015

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

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,208,956	0	21,208,956	30.00
31.00	03100	INTENSIVE CARE UNIT	4,271,363	0	4,271,363	31.00
40.00	04000	SUBPROVIDER - IPF	2,805,317	0	2,805,317	40.00
41.00	04100	SUBPROVIDER - IRF	3,342,693	0	3,342,693	41.00
43.00	04300	NURSERY	835,245	0	835,245	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,693,102	0	12,693,102	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,797,137	0	1,797,137	52.00
53.00	05300	ANESTHESIOLOGY	183,308	0	183,308	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,387,288	0	7,387,288	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	1,982,297	0	1,982,297	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	3,039,815	0	3,039,815	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	3,770,868	0	3,770,868	55.01
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,851,668	0	2,851,668	59.00
60.00	06000	LABORATORY	8,111,502	0	8,111,502	60.00
60.01	06001	FSED LABORATORY	1,498,344	0	1,498,344	60.01
65.00	06500	RESPIRATORY THERAPY	1,752,303	0	1,752,303	65.00
66.00	06600	PHYSICAL THERAPY	3,839,115	0	3,839,115	66.00
69.00	06900	ELECTROCARDIOLOGY	1,934,297	0	1,934,297	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,507,603	0	10,507,603	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,035,323	0	5,035,323	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,285,490	0	14,285,490	73.00
76.00	03950	CV RESOURCE CENTER	21,168	0	21,168	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	90.02
90.03	09003	INFUSION OP SERVICES	934,893	0	934,893	90.03
90.04	09004	MATERNAL HEA	0	0	0	90.04
91.00	09100	EMERGENCY	7,953,445	0	7,953,445	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	4,413,741	0	4,413,741	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	126,456,281	0	126,456,281	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	65,870	0	65,870	190.00
194.00	07950	RETAIL PHARMACY	0	0	0	194.00
194.01	07951	WORKING WELL	4,239,541	0	4,239,541	194.01
194.02	07952	APS DUNELAND SURG ASSOC	0	0	0	194.02
194.03	07953	MED WATCH	405,715	0	405,715	194.03
194.04	07954	OCCUPATIONAL MED CENTER	0	0	0	194.04
194.05	07955	PHYSICIAN PRACTICE	0	0	0	194.05
194.06	07956	DENTAL SERVICES	0	0	0	194.06
194.07	07957	DUNELAND MED WATCH	0	0	0	194.07
194.08	07958	WESTVILLE CLINIC	0	0	0	194.08
194.09	07959	ORTHOPEDI CS	0	0	0	194.09
194.10	07960	WOMEN SERVICES	303,806	0	303,806	194.10
194.11	07961	DUNELAND FITNESS CENTER	41,482	0	41,482	194.11
194.12	07962	CARDIOLOGY ASSOC	0	0	0	194.12
194.13	07963	DUNELAND FAMILY PRACTICE	0	0	0	194.13
194.14	07964	ORTHOPEDI CS	0	0	0	194.14
194.15	07965	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.15

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150015

Period:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
194.16	07966 PHYSICIAN PRACTICE MD WISE	8,521,608	0	8,521,608	194.16
194.17	07967 ENT	0	0	0	194.17
194.18	07968 SLEEP CLINIC	0	0	0	194.18
194.19	07969 HEALTH PARTNERS	50,599	0	50,599	194.19
194.20	07970 CENTER OF HOPE	53,101	0	53,101	194.20
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	140,138,003	0	140,138,003	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150015

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	54,328	16,871	71,199	71,199 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	813,318	1,016,030	1,829,348	7,915 5.00
7.00 00700	OPERATION OF PLANT	0	709,398	1,012,744	1,722,142	3,339 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	62,631	167	62,798	0 8.00
9.00 00900	HOUSEKEEPING	0	102,826	38,407	141,233	1,942 9.00
10.00 01000	DIETARY	0	44,871	23,318	68,189	537 10.00
11.00 01100	CAFETERIA	0	106,423	0	106,423	1,274 11.00
13.00 01300	NURSING ADMINISTRATION	0	25,583	254,589	280,172	3,136 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	98,945	104,979	203,924	143 14.00
15.00 01500	PHARMACY	0	47,329	3,754	51,083	2,541 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	43,822	13,297	57,119	6 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	984,937	124,550	1,109,487	13,279 30.00
31.00 03100	INTENSIVE CARE UNIT	0	88,379	165,850	254,229	3,169 31.00
40.00 04000	SUBPROVIDER - I PF	0	93,819	6,378	100,197	1,747 40.00
41.00 04100	SUBPROVIDER - I RF	0	169,803	39,144	208,947	1,466 41.00
43.00 04300	NURSERY	0	13,473	330	13,803	647 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
45.00 04500	NURSING FACILITY	0	0	0	0	0 45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	283,420	1,513,469	1,796,889	7,104 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	108,087	0	108,087	1,160 52.00
53.00 05300	ANESTHESIOLOGY	0	8,183	10,340	18,523	72 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	271,401	823,478	1,094,879	4,040 54.00
54.01 05401	FSED RADIOLOGY - DIAGNOSTIC	0	42,938	381,509	424,447	1,003 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	134,224	16,377	150,601	1,072 55.00
55.01 05501	WOODLAND CANCER CARE CENTER	0	160,152	1,258,988	1,419,140	1,059 55.01
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MRI	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	64,909	566,314	631,223	1,283 59.00
60.00 06000	LABORATORY	0	134,569	9,643	144,212	0 60.00
60.01 06001	FSED LABORATORY	0	19,483	155	19,638	0 60.01
65.00 06500	RESPIRATORY THERAPY	0	30,019	23,091	53,110	1,375 65.00
66.00 06600	PHYSICAL THERAPY	0	20,682	6,377	27,059	249 66.00
69.00 06900	ELECTROCARDIOLOGY	0	82,938	77,476	160,414	1,177 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03950	CV RESOURCE CENTER	0	0	0	0	20 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
90.01 09001	OB CLINIC	0	0	0	0	0 90.01
90.02 09002	PAIN MANAGEMENT	0	0	0	0	0 90.02
90.03 09003	INFUSION OP SERVICES	0	20,877	519	21,396	351 90.03
90.04 09004	MATERNAL HEA	0	0	0	0	0 90.04
91.00 09100	EMERGENCY	0	301,120	118,423	419,543	5,189 91.00
91.01 09101	FREE STANDING EMERGENCY DEPT	0	320,438	667,045	987,483	1,876 91.01
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	5,463,325	8,293,612	13,756,937	68,171 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,762	0	14,762	0 190.00
194.00 07950	RETAIL PHARMACY	0	0	0	0	0 194.00
194.01 07951	WORKING WELL	0	0	183,165	183,165	2,889 194.01
194.02 07952	APS DUNELAND SURG ASSOC	0	0	0	0	0 194.02
194.03 07953	MED WATCH	0	91,121	0	91,121	0 194.03
194.04 07954	OCCUPATIONAL MED CENTER	0	0	0	0	0 194.04
194.05 07955	PHYSICIAN PRACTICE	0	0	0	0	0 194.05
194.06 07956	DENTAL SERVICES	0	0	0	0	0 194.06
194.07 07957	DUNELAND MED WATCH	0	0	0	0	0 194.07
194.08 07958	WESTVILLE CLINIC	0	0	0	0	0 194.08
194.09 07959	ORTHOPEDICS	0	0	0	0	0 194.09
194.10 07960	WOMEN SERVICES	0	68,086	0	68,086	0 194.10
194.11 07961	DUNELAND FITNESS CENTER	0	0	34,086	34,086	0 194.11
194.12 07962	CARDIOLOGY ASSOC	0	0	0	0	0 194.12
194.13 07963	DUNELAND FAMILY PRACTICE	0	0	0	0	0 194.13
194.14 07964	ORTHOPEDICS	0	0	0	0	0 194.14

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150015

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

Worksheet B
Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
194.15 07965 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.15
194.16 07966 PHYSICIAN PRACTICE MD WISE	0	0	11,242	11,242	90	194.16
194.17 07967 ENT	0	0	0	0	0	194.17
194.18 07968 SLEEP CLINIC	0	0	0	0	0	194.18
194.19 07969 HEALTH PARTNERS	0	0	10,035	10,035	0	194.19
194.20 07970 CENTER OF HOPE	0	0	0	0	49	194.20
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	5,637,294	8,532,140	14,169,434	71,199	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150015

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

Worksheet B
Part II
Date/Time Prepared:
5/26/2016 5:19 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,837,263				5.00
7.00	00700	OPERATION OF PLANT	135,356	1,860,837			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,778	28,704	99,280		8.00
9.00	00900	HOUSEKEEPING	32,335	47,126	0	222,636	9.00
10.00	01000	DIETARY	9,948	20,565	40	2,565	101,844
11.00	01100	CAFETERIA	15,300	48,774	0	6,083	0
13.00	01300	NURSING ADMINISTRATION	45,934	11,725	0	1,462	0
14.00	01400	CENTRAL SERVICES & SUPPLY	18,739	45,347	0	5,656	0
15.00	01500	PHARMACY	180,561	21,691	0	2,705	0
16.00	01600	MEDICAL RECORDS & LIBRARY	22,931	20,084	0	2,505	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	199,981	451,401	46,661	56,302	66,325
31.00	03100	INTENSIVE CARE UNIT	45,194	40,504	4,964	5,052	10,263
40.00	04000	SUBPROVIDER - I/PF	28,304	42,998	10,921	5,363	10,496
41.00	04100	SUBPROVIDER - I/RF	32,349	77,822	3,971	9,706	10,118
43.00	04300	NURSERY	9,777	6,175	30	770	4,642
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	137,815	129,893	5,262	16,201	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,863	49,537	0	6,179	0
53.00	05300	ANESTHESIOLOGY	1,819	3,750	0	468	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	80,237	124,385	3,991	15,514	0
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	23,152	19,679	0	2,454	0
55.00	05500	RADIOLOGY-THERAPEUTIC	33,354	61,516	50	7,673	0
55.01	05501	WOODLAND CANCER CARE CENTER	42,095	73,399	993	9,155	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	30,926	29,748	30	3,710	0
60.00	06000	LABORATORY	98,477	61,674	0	7,692	0
60.01	06001	FSED LABORATORY	18,563	8,929	0	1,114	0
65.00	06500	RESPIRATORY THERAPY	20,649	13,758	0	1,716	0
66.00	06600	PHYSICAL THERAPY	47,456	9,479	2,978	1,182	0
69.00	06900	ELECTROCARDIOLOGY	20,384	38,011	496	4,741	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	120,389	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	58,986	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03950	CV RESOURCE CENTER	272	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	OB CLINIC	0	0	0	0	0
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0
90.03	09003	INFUSION OP SERVICES	10,153	9,568	30	1,193	0
90.04	09004	MATERNAL HEA	0	0	0	0	0
91.00	09100	EMERGENCY	77,864	138,005	9,928	17,213	0
91.01	09101	FREE STANDING EMERGENCY DEPT	42,888	146,859	3,971	18,317	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,668,829	1,781,106	94,316	212,691	101,844
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	236	6,766	0	844	0
194.00	07950	RETAIL PHARMACY	0	0	0	0	0
194.01	07951	WORKING WELL	52,615	0	0	0	0
194.02	07952	APS DUNELAND SURG ASSOC	0	0	0	0	0
194.03	07953	MED WATCH	1,445	41,761	0	5,209	0
194.04	07954	OCCUPATIONAL MED CENTER	0	0	0	0	0
194.05	07955	PHYSICIAN PRACTICE	0	0	0	0	0
194.06	07956	DENTAL SERVICES	0	0	0	0	0
194.07	07957	DUNELAND MED WATCH	0	0	0	0	0
194.08	07958	WESTVILLE CLINIC	0	0	0	0	0
194.09	07959	ORTHOPEDICS	0	0	0	0	0
194.10	07960	WOMEN SERVICES	1,088	31,204	0	3,892	0
194.11	07961	DUNELAND FITNESS CENTER	544	0	0	0	0
194.12	07962	CARDIOLOGY ASSOC	0	0	0	0	0
194.13	07963	DUNELAND FAMILY PRACTICE	0	0	0	0	0
194.14	07964	ORTHOPEDICS	0	0	0	0	0
194.15	07965	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.16	07966	PHYSICIAN PRACTICE MD WISE	111,690	0	0	0	0
194.17	07967	ENT	0	0	0	0	0
194.18	07968	SLEEP CLINIC	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150015			Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 5/26/2016 5:19 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
194.19	07969 HEALTH PARTNERS	170	0	4,964	0	0	0	194.19
194.20	07970 CENTER OF HOPE	646	0	0	0	0	0	194.20
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,837,263	1,860,837	99,280	222,636	101,844		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150015		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 5/26/2016 5:19 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						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	177,854					11.00
13.00	01300	8,359	350,788				13.00
14.00	01400	1,061	0	274,870			14.00
15.00	01500	6,456	0	0	265,037		15.00
16.00	01600	161	0	0	0	102,806	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	44,823	126,558	0	0	6,330	30.00
31.00	03100	8,240	30,626	0	0	1,052	31.00
40.00	04000	5,794	10,032	0	0	666	40.00
41.00	04100	6,478	12,150	0	0	1,241	41.00
43.00	04300	0	0	0	0	238	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	24,751	62,073	0	0	19,906	50.00
52.00	05200	0	0	0	0	426	52.00
53.00	05300	336	0	0	0	823	53.00
54.00	05400	12,563	0	0	0	13,561	54.00
54.01	05401	3,023	0	0	0	2,790	54.01
55.00	05500	2,520	0	0	0	2,096	55.00
55.01	05501	3,029	0	0	0	403	55.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	3,158	19,032	0	0	3,079	59.00
60.00	06000	0	0	0	0	8,885	60.00
60.01	06001	0	0	0	0	1,047	60.01
65.00	06500	4,633	0	0	0	2,200	65.00
66.00	06600	8,672	0	0	0	3,039	66.00
69.00	06900	3,646	2,779	0	0	2,538	69.00
71.00	07100	0	0	198,088	0	3,099	71.00
72.00	07200	0	0	76,782	0	2,430	72.00
73.00	07300	0	0	0	265,037	16,537	73.00
76.00	03950	48	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	1,007	7,200	0	0	482	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	14,811	65,885	0	0	8,118	91.00
91.01	09101	4,652	0	0	0	1,820	91.01
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		168,221	336,335	274,870	265,037	102,806	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	9,188	14,215	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
194.10	07960	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
194.12	07962	0	0	0	0	0	194.12
194.13	07963	0	0	0	0	0	194.13
194.14	07964	0	0	0	0	0	194.14
194.15	07965	0	0	0	0	0	194.15
194.16	07966	290	0	0	0	0	194.16
194.17	07967	0	0	0	0	0	194.17

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150015			Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 5/26/2016 5:19 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
194.18	07968 SLEEP CLINIC	0	0	0	0	0	0	194.18
194.19	07969 HEALTH PARTNERS	0	0	0	0	0	0	194.19
194.20	07970 CENTER OF HOPE	155	238	0	0	0	0	194.20
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	177,854	350,788	274,870	265,037	102,806	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150015

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

Worksheet B
Part II
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,121,147	0	2,121,147	30.00
31.00	03100	INTENSIVE CARE UNIT	403,293	0	403,293	31.00
40.00	04000	SUBPROVIDER - IPF	216,518	0	216,518	40.00
41.00	04100	SUBPROVIDER - IRF	364,248	0	364,248	41.00
43.00	04300	NURSERY	36,082	0	36,082	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,199,894	0	2,199,894	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	184,252	0	184,252	52.00
53.00	05300	ANESTHESIOLOGY	25,791	0	25,791	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,349,170	0	1,349,170	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	476,548	0	476,548	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	258,882	0	258,882	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	1,549,273	0	1,549,273	55.01
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	722,189	0	722,189	59.00
60.00	06000	LABORATORY	320,940	0	320,940	60.00
60.01	06001	FSED LABORATORY	49,291	0	49,291	60.01
65.00	06500	RESPIRATORY THERAPY	97,441	0	97,441	65.00
66.00	06600	PHYSICAL THERAPY	100,114	0	100,114	66.00
69.00	06900	ELECTROCARDIOLOGY	234,186	0	234,186	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	321,576	0	321,576	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	138,198	0	138,198	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	281,574	0	281,574	73.00
76.00	03950	CV RESOURCE CENTER	340	0	340	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	90.02
90.03	09003	INFUSION OP SERVICES	51,380	0	51,380	90.03
90.04	09004	MATERNAL HEA	0	0	0	90.04
91.00	09100	EMERGENCY	756,556	0	756,556	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	1,207,866	0	1,207,866	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,466,749	0	13,466,749	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,608	0	22,608	190.00
194.00	07950	RETAIL PHARMACY	0	0	0	194.00
194.01	07951	WORKING WELL	262,072	0	262,072	194.01
194.02	07952	APS DUNELAND SURG ASSOC	0	0	0	194.02
194.03	07953	MED WATCH	139,536	0	139,536	194.03
194.04	07954	OCCUPATIONAL MED CENTER	0	0	0	194.04
194.05	07955	PHYSICIAN PRACTICE	0	0	0	194.05
194.06	07956	DENTAL SERVICES	0	0	0	194.06
194.07	07957	DUNELAND MED WATCH	0	0	0	194.07
194.08	07958	WESTVILLE CLINIC	0	0	0	194.08
194.09	07959	ORTHOPEDECS	0	0	0	194.09
194.10	07960	WOMEN SERVICES	104,270	0	104,270	194.10
194.11	07961	DUNELAND FITNESS CENTER	34,630	0	34,630	194.11
194.12	07962	CARDIOLOGY ASSOC	0	0	0	194.12
194.13	07963	DUNELAND FAMILY PRACTICE	0	0	0	194.13
194.14	07964	ORTHOPEDECS	0	0	0	194.14
194.15	07965	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.15

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150015

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

Worksheet B
Part II
Date/Time Prepared:
5/26/2016 5:19 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
194.16	07966 PHYSICIAN PRACTICE MD WISE	123,312	0	123,312	194.16
194.17	07967 ENT	0	0	0	194.17
194.18	07968 SLEEP CLINIC	0	0	0	194.18
194.19	07969 HEALTH PARTNERS	15,169	0	15,169	194.19
194.20	07970 CENTER OF HOPE	1,088	0	1,088	194.20
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	14,169,434	0	14,169,434	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150015

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

Worksheet B-1

Date/Time Prepared:
5/26/2016 5: 19 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	376,144				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		7,918,478			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,625	15,658	42,108,283		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	54,268	942,954	4,680,860	-25,171,625	114,966,378
7.00 00700	OPERATION OF PLANT	47,334	939,904	1,974,412	0	8,469,824
8.00 00800	LAUNDRY & LINEN SERVICE	4,179	155	0	0	486,724
9.00 00900	HOUSEKEEPING	6,861	35,645	1,148,367	0	2,023,364
10.00 01000	DIETARY	2,994	21,641	317,717	0	622,493
11.00 01100	CAFETERIA	7,101	0	753,526	0	957,404
13.00 01300	NURSING ADMINISTRATION	1,707	236,278	1,854,701	0	2,874,319
14.00 01400	CENTRAL SERVICES & SUPPLY	6,602	97,429	84,638	0	1,172,596
15.00 01500	PHARMACY	3,158	3,484	1,502,447	0	11,298,499
16.00 01600	MEDICAL RECORDS & LIBRARY	2,924	12,341	3,622	0	1,434,921
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	65,719	115,592	7,858,108	0	12,514,478
31.00 03100	INTENSIVE CARE UNIT	5,897	153,922	1,873,966	0	2,827,983
40.00 04000	SUBPROVIDER - I/PF	6,260	5,919	1,033,385	0	1,771,113
41.00 04100	SUBPROVIDER - I/RF	11,330	36,329	866,665	0	2,024,190
43.00 04300	NURSERY	899	306	382,409	0	611,767
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00 04500	NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	18,911	1,404,611	4,201,122	0	8,623,689
52.00 05200	DELIVERY ROOM & LABOR ROOM	7,212	0	685,707	0	1,180,312
53.00 05300	ANESTHESIOLOGY	546	9,596	42,344	0	113,829
54.00 05400	RADIOLOGY-DIAGNOSTIC	18,109	764,251	2,389,376	0	5,020,778
54.01 05401	FSED RADIOLOGY - DIAGNOSTIC	2,865	354,070	593,011	0	1,448,713
55.00 05500	RADIOLOGY-THERAPEUTIC	8,956	15,199	633,988	0	2,087,103
55.01 05501	WOODLAND CANCER CARE CENTER	10,686	1,168,438	626,204	0	2,634,046
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MRI	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	4,331	525,583	758,462	0	1,935,172
60.00 06000	LABORATORY	8,979	8,949	0	0	6,162,122
60.01 06001	FSED LABORATORY	1,300	144	0	0	1,161,537
65.00 06500	RESPIRATORY THERAPY	2,003	21,430	812,858	0	1,292,105
66.00 06600	PHYSICAL THERAPY	1,380	5,918	147,472	0	2,969,541
69.00 06900	ELECTROCARDIOLOGY	5,534	71,904	695,828	0	1,275,524
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	7,533,250
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,690,988
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00 03950	CV RESOURCE CENTER	0	0	11,644	0	17,029
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
90.01 09001	OB CLINIC	0	0	0	0	0
90.02 09002	PAIN MANAGEMENT	0	0	0	0	0
90.03 09003	INFUSION OP SERVICES	1,393	482	207,332	0	635,336
90.04 09004	MATERNAL HEA	0	0	0	0	0
91.00 09100	EMERGENCY	20,092	109,906	3,068,645	0	4,872,274
91.01 09101	FREE STANDING EMERGENCY DEPT	21,381	619,069	1,109,316	0	2,683,710
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	364,536	7,697,107	40,318,132	-25,171,625	104,426,733
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	985	0	0	0	14,762
194.00 07950	RETAIL PHARMACY	0	0	0	0	0
194.01 07951	WORKING WELL	0	169,991	1,708,163	0	3,292,350
194.02 07952	APS DUNELAND SURG ASSOC	0	0	0	0	0
194.03 07953	MED WATCH	6,080	0	0	0	90,402
194.04 07954	OCCUPATIONAL MED CENTER	0	0	0	0	0
194.05 07955	PHYSICIAN PRACTICE	0	0	0	0	0
194.06 07956	DENTAL SERVICES	0	0	0	0	0
194.07 07957	DUNELAND MED WATCH	0	0	0	0	0
194.08 07958	WESTVILLE CLNIC	0	0	0	0	0
194.09 07959	ORTHOPEDICS	0	0	0	0	0
194.10 07960	WOMEN SERVICES	4,543	0	0	0	68,086
194.11 07961	DUNELAND FITNESS CENTER	0	31,634	0	0	34,031
194.12 07962	CARDIOLOGY ASSOC	0	0	0	0	0
194.13 07963	DUNELAND FAMILY PRACTICE	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150015

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

Worksheet B-1

Date/Time Prepared:
5/26/2016 5:19 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
194.14 07964 ORTHOPEDICS	0	0	0	0	0	0	194.14
194.15 07965 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0	194.15
194.16 07966 PHYSICIAN PRACTICE MD WISE	0	10,433	53,100	0	0	6,988,927	194.16
194.17 07967 ENT	0	0	0	0	0	0	194.17
194.18 07968 SLEEP CLINIC	0	0	0	0	0	0	194.18
194.19 07969 HEALTH PARTNERS	0	9,313	0	0	0	10,642	194.19
194.20 07970 CENTER OF HOPE	0	0	28,888	0	0	40,445	194.20
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)	5,637,294	8,532,140	15,627,297			25,171,625	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	14.987063	1.077497	0.371122			0.218948	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			71,199			1,837,263	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001691			0.015981	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150015

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

Worksheet B-1

Date/Time Prepared:
5/26/2016 5:19 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	270,917					7.00
8.00	00800	4,179	720,181				8.00
9.00	00900	6,861	0	259,877			9.00
10.00	01000	2,994	288	2,994	116,375		10.00
11.00	01100	7,101	0	7,101	0	55,128	11.00
13.00	01300	1,707	0	1,707	0	2,591	13.00
14.00	01400	6,602	0	6,602	0	329	14.00
15.00	01500	3,158	0	3,158	0	2,001	15.00
16.00	01600	2,924	0	2,924	0	50	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	65,719	338,486	65,719	75,789	13,893	30.00
31.00	03100	5,897	36,009	5,897	11,727	2,554	31.00
40.00	04000	6,260	79,220	6,260	11,993	1,796	40.00
41.00	04100	11,330	28,807	11,330	11,562	2,008	41.00
43.00	04300	899	216	899	5,304	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	18,911	38,170	18,911	0	7,672	50.00
52.00	05200	7,212	0	7,212	0	0	52.00
53.00	05300	546	0	546	0	104	53.00
54.00	05400	18,109	28,951	18,109	0	3,894	54.00
54.01	05401	2,865	0	2,865	0	937	54.01
55.00	05500	8,956	360	8,956	0	781	55.00
55.01	05501	10,686	7,202	10,686	0	939	55.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	4,331	216	4,331	0	979	59.00
60.00	06000	8,979	0	8,979	0	0	60.00
60.01	06001	1,300	0	1,300	0	0	60.01
65.00	06500	2,003	0	2,003	0	1,436	65.00
66.00	06600	1,380	21,605	1,380	0	2,688	66.00
69.00	06900	5,534	3,601	5,534	0	1,130	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03950	0	0	0	0	15	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	1,393	216	1,393	0	312	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	20,092	72,018	20,092	0	4,591	91.00
91.01	09101	21,381	28,807	21,381	0	1,442	91.01
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		259,309	684,172	248,269	116,375	52,142	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	985	0	985	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	2,848	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	6,080	0	6,080	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
194.10	07960	4,543	0	4,543	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
194.12	07962	0	0	0	0	0	194.12
194.13	07963	0	0	0	0	0	194.13
194.14	07964	0	0	0	0	0	194.14
194.15	07965	0	0	0	0	0	194.15
194.16	07966	0	0	0	0	90	194.16

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150015

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

Worksheet B-1

Date/Time Prepared:
5/26/2016 5:19 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
	7.00	8.00	9.00	10.00	11.00	
194.17 07967 ENT	0	0	0	0	0	194.17
194.18 07968 SLEEP CLINIC	0	0	0	0	0	194.18
194.19 07969 HEALTH PARTNERS	0	36,009	0	0	0	194.19
194.20 07970 CENTER OF HOPE	0	0	0	0	48	194.20
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)	10,324,275	752,547	2,727,839	904,612	1,512,172	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	38.108627	1.044941	10.496654	7.773250	27.430199	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	1,860,837	99,280	222,636	101,844	177,854	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	6.868661	0.137854	0.856698	0.875136	3.226201	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150015

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

Worksheet B-1

Date/Time Prepared:
5/26/2016 5:19 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)		
		13.00	14.00	15.00	16.00		
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	13,252					13.00
14.00	01400	0	10,634,219				14.00
15.00	01500	0	0	100			15.00
16.00	01600	0	0	0	554,949,183		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,781	0	0	34,217,188		30.00
31.00	03100	1,157	0	0	5,685,737		31.00
40.00	04000	379	0	0	3,599,673		40.00
41.00	04100	459	0	0	6,706,287		41.00
43.00	04300	0	0	0	1,284,995		43.00
44.00	04400	0	0	0	0		44.00
45.00	04500	0	0	0	0		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,345	0	0	106,837,453		50.00
52.00	05200	0	0	0	2,304,160		52.00
53.00	05300	0	0	0	4,447,237		53.00
54.00	05400	0	0	0	73,303,009		54.00
54.01	05401	0	0	0	15,083,613		54.01
55.00	05500	0	0	0	11,330,601		55.00
55.01	05501	0	0	0	2,177,143		55.01
57.00	05700	0	0	0	0		57.00
58.00	05800	0	0	0	0		58.00
59.00	05900	719	0	0	16,643,322		59.00
60.00	06000	0	0	0	48,026,381		60.00
60.01	06001	0	0	0	5,660,939		60.01
65.00	06500	0	0	0	11,890,479		65.00
66.00	06600	0	0	0	16,427,099		66.00
69.00	06900	105	0	0	13,718,130		69.00
71.00	07100	0	7,663,715	0	16,753,890		71.00
72.00	07200	0	2,970,504	0	13,132,613		72.00
73.00	07300	0	0	100	89,391,190		73.00
76.00	03950	0	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0		90.00
90.01	09001	0	0	0	0		90.01
90.02	09002	0	0	0	0		90.02
90.03	09003	272	0	0	2,605,431		90.03
90.04	09004	0	0	0	0		90.04
91.00	09100	2,489	0	0	43,883,352		91.00
91.01	09101	0	0	0	9,839,261		91.01
92.00	09200	0	0	0	0		92.00
SPECIAL PURPOSE COST CENTERS							
118.00		12,706	10,634,219	100	554,949,183		118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0		190.00
194.00	07950	0	0	0	0		194.00
194.01	07951	537	0	0	0		194.01
194.02	07952	0	0	0	0		194.02
194.03	07953	0	0	0	0		194.03
194.04	07954	0	0	0	0		194.04
194.05	07955	0	0	0	0		194.05
194.06	07956	0	0	0	0		194.06
194.07	07957	0	0	0	0		194.07
194.08	07958	0	0	0	0		194.08
194.09	07959	0	0	0	0		194.09
194.10	07960	0	0	0	0		194.10
194.11	07961	0	0	0	0		194.11
194.12	07962	0	0	0	0		194.12
194.13	07963	0	0	0	0		194.13
194.14	07964	0	0	0	0		194.14
194.15	07965	0	0	0	0		194.15

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150015

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

Worksheet B-1

Date/Time Prepared:
5/26/2016 5:19 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)		
		13.00	14.00	15.00	16.00		
194.16	07966	PHYSICIAN PRACTICE MD WISE	0	0	0		194.16
194.17	07967	ENT	0	0	0		194.17
194.18	07968	SLEEP CLINIC	0	0	0		194.18
194.19	07969	HEALTH PARTNERS	0	0	0		194.19
194.20	07970	CENTER OF HOPE	9	0	0		194.20
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)	3,657,686	1,759,251	13,980,666	1,892,588	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	276.010112	0.165433	139,806.660000	0.003410	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	350,788	274,870	265,037	102,806	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	26.470570	0.025848	2,650.370000	0.000185	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150015		Period: From 01/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 5/26/2016 5:19 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		21,208,956		2,977	21,211,933	30.00
31.00	03100 INTENSIVE CARE UNIT		4,271,363		0	4,271,363	31.00
40.00	04000 SUBPROVIDER - I PF		2,805,317		3,058	2,808,375	40.00
41.00	04100 SUBPROVIDER - I RF		3,342,693		0	3,342,693	41.00
43.00	04300 NURSERY		835,245		0	835,245	43.00
44.00	04400 SKILLED NURSING FACILITY		0		0	0	44.00
45.00	04500 NURSING FACILITY		0		0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		12,693,102		81,144	12,774,246	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,797,137		0	1,797,137	52.00
53.00	05300 ANESTHESIOLOGY		183,308		2,288	185,596	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,387,288		0	7,387,288	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC		1,982,297		0	1,982,297	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC		3,039,815		0	3,039,815	55.00
55.01	05501 WOODLAND CANCER CARE CENTER		3,770,868		0	3,770,868	55.01
57.00	05700 CT SCAN		0		0	0	57.00
58.00	05800 MRI		0		0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		2,851,668		6,070	2,857,738	59.00
60.00	06000 LABORATORY		8,111,502		17,148	8,128,650	60.00
60.01	06001 FSED LABORATORY		1,498,344		0	1,498,344	60.01
65.00	06500 RESPIRATORY THERAPY	0	1,752,303		0	1,752,303	65.00
66.00	06600 PHYSICAL THERAPY	0	3,839,115		60,169	3,899,284	66.00
69.00	06900 ELECTROCARDIOLOGY		1,934,297		0	1,934,297	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		10,507,603		0	10,507,603	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		5,035,323		0	5,035,323	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		14,285,490		0	14,285,490	73.00
76.00	03950 CV RESOURCE CENTER		21,168		0	21,168	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		0		0	0	90.00
90.01	09001 OB CLINIC		0		0	0	90.01
90.02	09002 PAIN MANAGEMENT		0		0	0	90.02
90.03	09003 INFUSION OP SERVICES		934,893		0	934,893	90.03
90.04	09004 MATERNAL HEA		0		0	0	90.04
91.00	09100 EMERGENCY		7,953,445		6,250	7,959,695	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT		4,413,741		2,191	4,415,932	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		3,255,138			3,255,138	92.00
200.00	Subtotal (see instructions)	0	129,711,419		181,295	129,892,714	200.00
201.00	Less Observation Beds		3,255,138			3,255,138	201.00
202.00	Total (see instructions)	0	126,456,281		181,295	126,637,576	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150015		Period: From 01/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 5/26/2016 5:19 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,844,637		31,844,637			30.00
31.00	03100	INTENSIVE CARE UNIT	5,685,737		5,685,737			31.00
40.00	04000	SUBPROVIDER - IPF	3,599,673		3,599,673			40.00
41.00	04100	SUBPROVIDER - IRF	6,706,287		6,706,287			41.00
43.00	04300	NURSERY	1,284,995		1,284,995			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,300,663	80,536,790	106,837,453	0.118808	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,117,072	187,088	2,304,160	0.779953	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,697,589	2,749,648	4,447,237	0.041218	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,302,172	57,000,837	73,303,009	0.100777	0.000000	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	1,020,689	14,062,924	15,083,613	0.131421	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,297,369	10,033,232	11,330,601	0.268284	0.000000	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	24,583	2,152,560	2,177,143	1.732026	0.000000	55.01
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,343,003	9,300,319	16,643,322	0.171340	0.000000	59.00
60.00	06000	LABORATORY	18,141,997	29,884,384	48,026,381	0.168897	0.000000	60.00
60.01	06001	FSED LABORATORY	54,244	5,606,695	5,660,939	0.264681	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	10,695,362	1,195,117	11,890,479	0.147370	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,477,452	11,949,647	16,427,099	0.233706	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	5,208,162	8,509,968	13,718,130	0.141003	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,994,524	8,759,366	16,753,890	0.627174	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,393,802	4,738,811	13,132,613	0.383421	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,591,492	58,799,698	89,391,190	0.159809	0.000000	73.00
76.00	03950	CV RESOURCE CENTER	0	0	0	0.000000	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	OB CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.02
90.03	09003	INFUSION OP SERVICES	950,822	1,654,609	2,605,431	0.358825	0.000000	90.03
90.04	09004	MATERNAL HEA	0	0	0	0.000000	0.000000	90.04
91.00	09100	EMERGENCY	9,099,902	34,783,450	43,883,352	0.181241	0.000000	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	1,030,691	8,808,570	9,839,261	0.448585	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,372,551	2,372,551	1.371999	0.000000	92.00
200.00		Subtotal (see instructions)	201,862,919	353,086,264	554,949,183			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	201,862,919	353,086,264	554,949,183			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/26/2016 5:19 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
INPATIENT ROUTINE SERVICE COST CENTERS		11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
45.00	04500 NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.119567		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.779953		52.00
53.00	05300 ANESTHESIOLOGY	0.041733		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.100777		54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.131421		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.268284		55.00
55.01	05501 WOODLAND CANCER CARE CENTER	1.732026		55.01
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.171705		59.00
60.00	06000 LABORATORY	0.169254		60.00
60.01	06001 FSED LABORATORY	0.264681		60.01
65.00	06500 RESPIRATORY THERAPY	0.147370		65.00
66.00	06600 PHYSICAL THERAPY	0.237369		66.00
69.00	06900 ELECTROCARDIOLOGY	0.141003		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.627174		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.383421		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.159809		73.00
76.00	03950 CV RESOURCE CENTER	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 OB CLINIC	0.000000		90.01
90.02	09002 PAIN MANAGEMENT	0.000000		90.02
90.03	09003 INFUSION OP SERVICES	0.358825		90.03
90.04	09004 MATERNAL HEA	0.000000		90.04
91.00	09100 EMERGENCY	0.181383		91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.448807		91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.371999		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150015

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

Worksheet C
Part I
Date/Time Prepared:
5/26/2016 5:19 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	21,208,956		21,208,956	2,977	21,211,933	30.00
31.00	03100 INTENSIVE CARE UNIT	4,271,363		4,271,363	0	4,271,363	31.00
40.00	04000 SUBPROVIDER - I PF	2,805,317		2,805,317	3,058	2,808,375	40.00
41.00	04100 SUBPROVIDER - I RF	3,342,693		3,342,693	0	3,342,693	41.00
43.00	04300 NURSERY	835,245		835,245	0	835,245	43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500 NURSING FACILITY	0		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	12,693,102		12,693,102	81,144	12,774,246	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,797,137		1,797,137	0	1,797,137	52.00
53.00	05300 ANESTHESIOLOGY	183,308		183,308	2,288	185,596	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,387,288		7,387,288	0	7,387,288	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	1,982,297		1,982,297	0	1,982,297	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	3,039,815		3,039,815	0	3,039,815	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	3,770,868		3,770,868	0	3,770,868	55.01
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MRI	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	2,851,668		2,851,668	6,070	2,857,738	59.00
60.00	06000 LABORATORY	8,111,502		8,111,502	17,148	8,128,650	60.00
60.01	06001 FSED LABORATORY	1,498,344		1,498,344	0	1,498,344	60.01
65.00	06500 RESPIRATORY THERAPY	1,752,303	0	1,752,303	0	1,752,303	65.00
66.00	06600 PHYSICAL THERAPY	3,839,115	0	3,839,115	60,169	3,899,284	66.00
69.00	06900 ELECTROCARDIOLOGY	1,934,297		1,934,297	0	1,934,297	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10,507,603		10,507,603	0	10,507,603	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5,035,323		5,035,323	0	5,035,323	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	14,285,490		14,285,490	0	14,285,490	73.00
76.00	03950 CV RESOURCE CENTER	21,168		21,168	0	21,168	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
90.01	09001 OB CLINIC	0		0	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0		0	0	0	90.02
90.03	09003 INFUSION OP SERVICES	934,893		934,893	0	934,893	90.03
90.04	09004 MATERNAL HEA	0		0	0	0	90.04
91.00	09100 EMERGENCY	7,953,445		7,953,445	6,250	7,959,695	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	4,413,741		4,413,741	2,191	4,415,932	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3,255,138		3,255,138	0	3,255,138	92.00
200.00	Subtotal (see instructions)	129,711,419	0	129,711,419	181,295	129,892,714	200.00
201.00	Less Observation Beds	3,255,138		3,255,138	0	3,255,138	201.00
202.00	Total (see instructions)	126,456,281	0	126,456,281	181,295	126,637,576	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150015		Period: From 01/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 5/26/2016 5:19 pm	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,844,637		31,844,637			30.00
31.00	03100	INTENSIVE CARE UNIT	5,685,737		5,685,737			31.00
40.00	04000	SUBPROVIDER - IPF	3,599,673		3,599,673			40.00
41.00	04100	SUBPROVIDER - IRF	6,706,287		6,706,287			41.00
43.00	04300	NURSERY	1,284,995		1,284,995			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,300,663	80,536,790	106,837,453	0.118808	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,117,072	187,088	2,304,160	0.779953	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,697,589	2,749,648	4,447,237	0.041218	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,302,172	57,000,837	73,303,009	0.100777	0.000000	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	1,020,689	14,062,924	15,083,613	0.131421	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,297,369	10,033,232	11,330,601	0.268284	0.000000	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	24,583	2,152,560	2,177,143	1.732026	0.000000	55.01
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,343,003	9,300,319	16,643,322	0.171340	0.000000	59.00
60.00	06000	LABORATORY	18,141,997	29,884,384	48,026,381	0.168897	0.000000	60.00
60.01	06001	FSED LABORATORY	54,244	5,606,695	5,660,939	0.264681	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	10,695,362	1,195,117	11,890,479	0.147370	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,477,452	11,949,647	16,427,099	0.233706	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	5,208,162	8,509,968	13,718,130	0.141003	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,994,524	8,759,366	16,753,890	0.627174	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,393,802	4,738,811	13,132,613	0.383421	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,591,492	58,799,698	89,391,190	0.159809	0.000000	73.00
76.00	03950	CV RESOURCE CENTER	0	0	0	0.000000	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	OB CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.02
90.03	09003	INFUSION OP SERVICES	950,822	1,654,609	2,605,431	0.358825	0.000000	90.03
90.04	09004	MATERNAL HEA	0	0	0	0.000000	0.000000	90.04
91.00	09100	EMERGENCY	9,099,902	34,783,450	43,883,352	0.181241	0.000000	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	1,030,691	8,808,570	9,839,261	0.448585	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,372,551	2,372,551	1.371999	0.000000	92.00
200.00		Subtotal (see instructions)	201,862,919	353,086,264	554,949,183			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	201,862,919	353,086,264	554,949,183			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/26/2016 5:19 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
45.00	04500 NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.000000		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0.000000		55.01
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 FSED LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950 CV RESOURCE CENTER	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 OB CLINIC	0.000000		90.01
90.02	09002 PAIN MANAGEMENT	0.000000		90.02
90.03	09003 INFUSION OP SERVICES	0.000000		90.03
90.04	09004 MATERNAL HEA	0.000000		90.04
91.00	09100 EMERGENCY	0.000000		91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.000000		91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part I Date/Time Prepared: 5/26/2016 5:19 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,121,147	0	2,121,147	19,595	108.25	30.00
31.00	INTENSIVE CARE UNIT	403,293		403,293	2,779	145.12	31.00
40.00	SUBPROVIDER - IPF	216,518	0	216,518	2,842	76.19	40.00
41.00	SUBPROVIDER - IRF	364,248	0	364,248	2,740	132.94	41.00
43.00	NURSERY	36,082		36,082	1,257	28.70	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (Lines 30-199)	3,141,288		3,141,288	29,213		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	9,500	1,028,375				
31.00	INTENSIVE CARE UNIT	1,315	190,833				
40.00	SUBPROVIDER - IPF	796	60,647				
41.00	SUBPROVIDER - IRF	1,992	264,816				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
45.00	NURSING FACILITY	0	0				
200.00	Total (Lines 30-199)	13,603	1,544,671				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 5/26/2016 5:19 pm
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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	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,199,894	106,837,453	0.020591	11,565,108	238,137	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	184,252	2,304,160	0.079965	6,196	495	52.00
53.00	05300 ANESTHESIOLOGY	25,791	4,447,237	0.005799	755,101	4,379	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,349,170	73,303,009	0.018405	9,102,243	167,527	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	476,548	15,083,613	0.031594	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	258,882	11,330,601	0.022848	849,982	19,420	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	1,549,273	2,177,143	0.711608	0	0	55.01
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MRI	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	722,189	16,643,322	0.043392	3,571,095	154,957	59.00
60.00	06000 LABORATORY	320,940	48,026,381	0.006683	9,349,952	62,486	60.00
60.01	06001 FSED LABORATORY	49,291	5,660,939	0.008707	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	97,441	11,890,479	0.008195	6,236,695	51,110	65.00
66.00	06600 PHYSICAL THERAPY	100,114	16,427,099	0.006094	1,602,859	9,768	66.00
69.00	06900 ELECTROCARDIOLOGY	234,186	13,718,130	0.017071	3,046,786	52,012	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	321,576	16,753,890	0.019194	2,921,165	56,069	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	138,198	13,132,613	0.010523	4,295,073	45,197	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	281,574	89,391,190	0.003150	16,243,433	51,167	73.00
76.00	03950 CV RESOURCE CENTER	340	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09001 OB CLINIC	0	0	0.000000	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0	0	0.000000	0	0	90.02
90.03	09003 INFUSION OP SERVICES	51,380	2,605,431	0.019720	663,281	13,080	90.03
90.04	09004 MATERNAL HEA	0	0	0.000000	0	0	90.04
91.00	09100 EMERGENCY	756,556	43,883,352	0.017240	3,998,867	68,940	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	1,207,866	9,839,261	0.122760	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	325,507	2,372,551	0.137197	0	0	92.00
200.00	Total (lines 50-199)	10,650,968	505,827,854		74,207,836	994,744	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part III Date/Time Prepared: 5/26/2016 5:19 pm
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Cost Center Description			Title XVIII		Hospital		PPS
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0 40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
43.00	04300	NURSERY	0	0	0	0	0 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0 45.00
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	19,595	0.00	9,500	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,779	0.00	1,315	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,842	0.00	796	0	40.00
41.00	04100	SUBPROVIDER - IRF	2,740	0.00	1,992	0	41.00
43.00	04300	NURSERY	1,257	0.00	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0	45.00
200.00		Total (lines 30-199)	29,213		13,603	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/26/2016 5:19 pm
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Cost Center Description		Title XVIII				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0	0	0	0	0	55.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 FSED LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950 CV RESOURCE CENTER	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OB CLINIC	0	0	0	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09003 INFUSION OP SERVICES	0	0	0	0	0	90.03
90.04	09004 MATERNAL HEA	0	0	0	0	0	90.04
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0	0	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/26/2016 5:19 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	106,837,453	0.000000	0.000000	11,565,108	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,304,160	0.000000	0.000000	6,196	52.00
53.00	05300	ANESTHESIOLOGY	0	4,447,237	0.000000	0.000000	755,101	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	73,303,009	0.000000	0.000000	9,102,243	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0	15,083,613	0.000000	0.000000	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	11,330,601	0.000000	0.000000	849,982	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	0	2,177,143	0.000000	0.000000	0	55.01
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	16,643,322	0.000000	0.000000	3,571,095	59.00
60.00	06000	LABORATORY	0	48,026,381	0.000000	0.000000	9,349,952	60.00
60.01	06001	FSED LABORATORY	0	5,660,939	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	11,890,479	0.000000	0.000000	6,236,695	65.00
66.00	06600	PHYSICAL THERAPY	0	16,427,099	0.000000	0.000000	1,602,859	66.00
69.00	06900	ELECTROCARDIOLOGY	0	13,718,130	0.000000	0.000000	3,046,786	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,753,890	0.000000	0.000000	2,921,165	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,132,613	0.000000	0.000000	4,295,073	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	89,391,190	0.000000	0.000000	16,243,433	73.00
76.00	03950	CV RESOURCE CENTER	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	OB CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0.000000	0.000000	0	90.02
90.03	09003	INFUSION OP SERVICES	0	2,605,431	0.000000	0.000000	663,281	90.03
90.04	09004	MATERNAL HEA	0	0	0.000000	0.000000	0	90.04
91.00	09100	EMERGENCY	0	43,883,352	0.000000	0.000000	3,998,867	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0	9,839,261	0.000000	0.000000	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,372,551	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	505,827,854			74,207,836	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/26/2016 5:19 pm
	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)	
	ANCILLARY SERVICE COST CENTERS	11.00	12.00	13.00	
50.00	05000 OPERATING ROOM	0	28,713,036	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	777,864	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	22,116,927	0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	517,390	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	2,986,025	0	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0	57,905	0	55.01
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	4,726,871	0	59.00
60.00	06000 LABORATORY	0	5,684,946	0	60.00
60.01	06001 FSED LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	452,593	0	65.00
66.00	06600 PHYSICAL THERAPY	0	8,881	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	3,272,208	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,870,200	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,441,340	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	31,496,981	0	73.00
76.00	03950 CV RESOURCE CENTER	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 OB CLINIC	0	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0	0	0	90.02
90.03	09003 INFUSION OP SERVICES	0	747,955	0	90.03
90.04	09004 MATERNAL HEA	0	0	0	90.04
91.00	09100 EMERGENCY	0	6,649,270	0	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1,179,103	0	92.00
200.00	Total (lines 50-199)	0	113,699,495	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/26/2016 5:19 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.118808	28,713,036	0	0	3,411,338	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.779953	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.041218	777,864	0	0	32,062	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100777	22,116,927	0	0	2,228,878	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0.131421	517,390	0	0	67,996	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.268284	2,986,025	0	0	801,103	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	1.732026	57,905	0	0	100,293	55.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.171340	4,726,871	0	0	809,902	59.00
60.00	06000	LABORATORY	0.168897	5,684,946	580	0	960,170	60.00
60.01	06001	FSED LABORATORY	0.264681	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.147370	452,593	0	0	66,699	65.00
66.00	06600	PHYSICAL THERAPY	0.233706	8,881	0	0	2,076	66.00
69.00	06900	ELECTROCARDIOLOGY	0.141003	3,272,208	0	0	461,391	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.627174	1,870,200	0	0	1,172,941	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.383421	2,441,340	0	0	936,061	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159809	31,496,981	0	53,276	5,033,501	73.00
76.00	03950	CV RESOURCE CENTER	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OB CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
90.03	09003	INFUSION OP SERVICES	0.358825	747,955	0	0	268,385	90.03
90.04	09004	MATERNAL HEA	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.181241	6,649,270	0	0	1,205,120	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0.448585	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.371999	1,179,103	0	0	1,617,728	92.00
200.00		Subtotal (see instructions)		113,699,495	580	53,276	19,175,644	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		113,699,495	580	53,276	19,175,644	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/26/2016 5:19 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01 05501 WOODLAND CANCER CARE CENTER	0	0		55.01
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	98	0		60.00
60.01 06001 FSED LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
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	8,514		73.00
76.00 03950 CV RESOURCE CENTER	0	0		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 OB CLINIC	0	0		90.01
90.02 09002 PAIN MANAGEMENT	0	0		90.02
90.03 09003 INFUSION OP SERVICES	0	0		90.03
90.04 09004 MATERNAL HEA	0	0		90.04
91.00 09100 EMERGENCY	0	0		91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0	0		91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	98	8,514		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	98	8,514		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150015 Component CCN: 15S015		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part II Date/Time Prepared: 5/26/2016 5:19 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,199,894	106,837,453	0.020591	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	184,252	2,304,160	0.079965	0	0	52.00
53.00	05300 ANESTHESIOLOGY	25,791	4,447,237	0.005799	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,349,170	73,303,009	0.018405	39,921	735	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	476,548	15,083,613	0.031594	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	258,882	11,330,601	0.022848	0	0	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	1,549,273	2,177,143	0.711608	0	0	55.01
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MRI	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	722,189	16,643,322	0.043392	0	0	59.00
60.00	06000 LABORATORY	320,940	48,026,381	0.006683	112,068	749	60.00
60.01	06001 FSED LABORATORY	49,291	5,660,939	0.008707	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	97,441	11,890,479	0.008195	20,734	170	65.00
66.00	06600 PHYSICAL THERAPY	100,114	16,427,099	0.006094	11,622	71	66.00
69.00	06900 ELECTROCARDIOLOGY	234,186	13,718,130	0.017071	4,892	84	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	321,576	16,753,890	0.019194	5,589	107	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	138,198	13,132,613	0.010523	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	281,574	89,391,190	0.003150	221,724	698	73.00
76.00	03950 CV RESOURCE CENTER	340	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09001 OB CLINIC	0	0	0.000000	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0	0	0.000000	0	0	90.02
90.03	09003 INFUSION OP SERVICES	51,380	2,605,431	0.019720	0	0	90.03
90.04	09004 MATERNAL HEA	0	0	0.000000	0	0	90.04
91.00	09100 EMERGENCY	756,556	43,883,352	0.017240	107,148	1,847	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	1,207,866	9,839,261	0.122760	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,372,551	0.000000	0	0	92.00
200.00	Total (lines 50-199)	10,325,461	505,827,854		523,698	4,461	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150015 Component CCN: 15S015	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/26/2016 5:19 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	FSED LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
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
76.00	03950	CV RESOURCE CENTER	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	90.02
90.03	09003	INFUSION OP SERVICES	0	0	0	0	90.03
90.04	09004	MATERNAL HEA	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0	0	0	0	91.01
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: 150015 Component CCN: 15S015	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/26/2016 5:19 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	106,837,453	0.000000	0.000000	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2,304,160	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	4,447,237	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	73,303,009	0.000000	0.000000	39,921	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	15,083,613	0.000000	0.000000	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	11,330,601	0.000000	0.000000	0	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0	2,177,143	0.000000	0.000000	0	55.01
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MRI	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	16,643,322	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	48,026,381	0.000000	0.000000	112,068	60.00
60.01	06001 FSED LABORATORY	0	5,660,939	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	11,890,479	0.000000	0.000000	20,734	65.00
66.00	06600 PHYSICAL THERAPY	0	16,427,099	0.000000	0.000000	11,622	66.00
69.00	06900 ELECTROCARDIOLOGY	0	13,718,130	0.000000	0.000000	4,892	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,753,890	0.000000	0.000000	5,589	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	13,132,613	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	89,391,190	0.000000	0.000000	221,724	73.00
76.00	03950 CV RESOURCE CENTER	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001 OB CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002 PAIN MANAGEMENT	0	0	0.000000	0.000000	0	90.02
90.03	09003 INFUSION OP SERVICES	0	2,605,431	0.000000	0.000000	0	90.03
90.04	09004 MATERNAL HEA	0	0	0.000000	0.000000	0	90.04
91.00	09100 EMERGENCY	0	43,883,352	0.000000	0.000000	107,148	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0	9,839,261	0.000000	0.000000	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,372,551	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	505,827,854			523,698	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150015 Component CCN: 15S015	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/26/2016 5:19 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0	0	0	55.01
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 FSED LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03950 CV RESOURCE CENTER	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 OB CLINIC	0	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0	0	0	90.02
90.03	09003 INFUSION OP SERVICES	0	0	0	90.03
90.04	09004 MATERNAL HEA	0	0	0	90.04
91.00	09100 EMERGENCY	0	0	0	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0	0	0	91.01
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 INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150015 Component CCN: 15T015	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 5/26/2016 5:19 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,199,894	106,837,453	0.020591	95,784	1,972	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	184,252	2,304,160	0.079965	0	0	52.00
53.00	05300 ANESTHESIOLOGY	25,791	4,447,237	0.005799	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,349,170	73,303,009	0.018405	167,123	3,076	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	476,548	15,083,613	0.031594	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	258,882	11,330,601	0.022848	8,187	187	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	1,549,273	2,177,143	0.711608	0	0	55.01
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MRI	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	722,189	16,643,322	0.043392	0	0	59.00
60.00	06000 LABORATORY	320,940	48,026,381	0.006683	265,687	1,776	60.00
60.01	06001 FSED LABORATORY	49,291	5,660,939	0.008707	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	97,441	11,890,479	0.008195	245,023	2,008	65.00
66.00	06600 PHYSICAL THERAPY	100,114	16,427,099	0.006094	2,613,563	15,927	66.00
69.00	06900 ELECTROCARDIOLOGY	234,186	13,718,130	0.017071	35,619	608	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	321,576	16,753,890	0.019194	107,804	2,069	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	138,198	13,132,613	0.010523	5,871	62	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	281,574	89,391,190	0.003150	627,995	1,978	73.00
76.00	03950 CV RESOURCE CENTER	340	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09001 OB CLINIC	0	0	0.000000	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0	0	0.000000	0	0	90.02
90.03	09003 INFUSION OP SERVICES	51,380	2,605,431	0.019720	0	0	90.03
90.04	09004 MATERNAL HEA	0	0	0.000000	0	0	90.04
91.00	09100 EMERGENCY	756,556	43,883,352	0.017240	0	0	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	1,207,866	9,839,261	0.122760	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,372,551	0.000000	0	0	92.00
200.00	Total (lines 50-199)	10,325,461	505,827,854		4,172,656	29,663	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150015 Component CCN: 15T015	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/26/2016 5:19 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	FSED LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
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
76.00	03950	CV RESOURCE CENTER	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	90.02
90.03	09003	INFUSION OP SERVICES	0	0	0	0	90.03
90.04	09004	MATERNAL HEA	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0	0	0	0	91.01
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: 150015 Component CCN: 15T015	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/26/2016 5:19 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 + col. 7)	
	6.00	7.00	8.00	9.00	10.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	106,837,453	0.000000	0.000000	95,784
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	2,304,160	0.000000	0.000000	0
53.00 05300 ANESTHESIOLOGY	0	4,447,237	0.000000	0.000000	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	73,303,009	0.000000	0.000000	167,123
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	15,083,613	0.000000	0.000000	0
55.00 05500 RADIOLOGY-THERAPEUTIC	0	11,330,601	0.000000	0.000000	8,187
55.01 05501 WOODLAND CANCER CARE CENTER	0	2,177,143	0.000000	0.000000	0
57.00 05700 CT SCAN	0	0	0.000000	0.000000	0
58.00 05800 MRI	0	0	0.000000	0.000000	0
59.00 05900 CARDIAC CATHETERIZATION	0	16,643,322	0.000000	0.000000	0
60.00 06000 LABORATORY	0	48,026,381	0.000000	0.000000	265,687
60.01 06001 FSED LABORATORY	0	5,660,939	0.000000	0.000000	0
65.00 06500 RESPIRATORY THERAPY	0	11,890,479	0.000000	0.000000	245,023
66.00 06600 PHYSICAL THERAPY	0	16,427,099	0.000000	0.000000	2,613,563
69.00 06900 ELECTROCARDIOLOGY	0	13,718,130	0.000000	0.000000	35,619
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,753,890	0.000000	0.000000	107,804
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	13,132,613	0.000000	0.000000	5,871
73.00 07300 DRUGS CHARGED TO PATIENTS	0	89,391,190	0.000000	0.000000	627,995
76.00 03950 CV RESOURCE CENTER	0	0	0.000000	0.000000	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	0	0.000000	0.000000	0
90.01 09001 OB CLINIC	0	0	0.000000	0.000000	0
90.02 09002 PAIN MANAGEMENT	0	0	0.000000	0.000000	0
90.03 09003 INFUSION OP SERVICES	0	2,605,431	0.000000	0.000000	0
90.04 09004 MATERNAL HEA	0	0	0.000000	0.000000	0
91.00 09100 EMERGENCY	0	43,883,352	0.000000	0.000000	0
91.01 09101 FREE STANDING EMERGENCY DEPT	0	9,839,261	0.000000	0.000000	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,372,551	0.000000	0.000000	0
200.00 Total (lines 50-199)	0	505,827,854			4,172,656

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/26/2016 5:19 pm
	Component CCN: 15T015	Title XVIII	Subprovider - IRF PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
55.01 05501 WOODLAND CANCER CARE CENTER	0	0	0	55.01
57.00 05700 CT SCAN	0	0	0	57.00
58.00 05800 MRI	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	60.00
60.01 06001 FSED LABORATORY	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 03950 CV RESOURCE CENTER	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
90.01 09001 OB CLINIC	0	0	0	90.01
90.02 09002 PAIN MANAGEMENT	0	0	0	90.02
90.03 09003 INFUSION OP SERVICES	0	0	0	90.03
90.04 09004 MATERNAL HEA	0	0	0	90.04
91.00 09100 EMERGENCY	0	0	0	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/26/2016 5:19 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		19,595	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19,595	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		16,588	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)		9,500	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		21,211,933	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)		21,211,933	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		21,211,933	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,082.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		10,283,940	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)		10,283,940	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/26/2016 5:19 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	4,271,363	2,779	1,537.01	1,315	2,021,168		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					13,527,429		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					25,832,537		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,219,208		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					994,744		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,213,952		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					23,618,585		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					3,007		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,082.52		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					3,255,138		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/26/2016 5:19 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,121,147	21,211,933	0.099998	3,255,138	325,507	90.00
91.00	Nursing School cost	0	21,211,933	0.000000	3,255,138	0	91.00
92.00	Allied health cost	0	21,211,933	0.000000	3,255,138	0	92.00
93.00	All other Medical Education	0	21,211,933	0.000000	3,255,138	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015 Component CCN: 15S015	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/26/2016 5:19 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,842	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,842	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)		2,842	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)		796	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,808,375	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,808,375	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,808,375	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		988.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		786,583	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)		786,583	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
		Component CCN: 15S015				Date/Time Prepared: 5/26/2016 5:19 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
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)					87,869		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					874,452		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					60,647		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					4,461		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					65,108		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					809,344		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015 Component CCN: 15S015		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/26/2016 5:19 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	216,518	2,808,375	0.077097	0	0	90.00
91.00	Nursing School cost	0	2,808,375	0.000000	0	0	91.00
92.00	Allied health cost	0	2,808,375	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,808,375	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015 Component CCN: 15T015	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/26/2016 5:19 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,740	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,740	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)		2,740	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)		1,992	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,342,693	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,342,693	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,342,693	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,219.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,430,160	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,430,160	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
		Component CCN: 15T015				Date/Time Prepared: 5/26/2016 5:19 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					907,192		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,337,352		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					264,816		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					29,663		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					294,479		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,042,873		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015 Component CCN: 15T015		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/26/2016 5:19 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	364,248	3,342,693	0.108968	0	0	90.00
91.00	Nursing School cost	0	3,342,693	0.000000	0	0	91.00
92.00	Allied health cost	0	3,342,693	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,342,693	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/26/2016 5:19 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		14,484,993		30.00
31.00	03100 INTENSIVE CARE UNIT		2,746,649		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.119567	11,565,108	1,382,805	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.779953	6,196	4,833	52.00
53.00	05300 ANESTHESIOLOGY	0.041733	755,101	31,513	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.100777	9,102,243	917,297	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.131421	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.268284	849,982	228,037	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	1.732026	0	0	55.01
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.171705	3,571,095	613,175	59.00
60.00	06000 LABORATORY	0.169254	9,349,952	1,582,517	60.00
60.01	06001 FSED LABORATORY	0.264681	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.147370	6,236,695	919,102	65.00
66.00	06600 PHYSICAL THERAPY	0.237369	1,602,859	380,469	66.00
69.00	06900 ELECTROCARDIOLOGY	0.141003	3,046,786	429,606	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.627174	2,921,165	1,832,079	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.383421	4,295,073	1,646,821	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.159809	16,243,433	2,595,847	73.00
76.00	03950 CV RESOURCE CENTER	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 OB CLINIC	0.000000	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0.000000	0	0	90.02
90.03	09003 INFUSION OP SERVICES	0.358825	663,281	238,002	90.03
90.04	09004 MATERNAL HEA	0.000000	0	0	90.04
91.00	09100 EMERGENCY	0.181383	3,998,867	725,326	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.448807	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.371999	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		74,207,836	13,527,429	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)		74,207,836		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150015 Component CCN: 15S015	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/26/2016 5:19 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		1,002,120		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.119567	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.779953	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.041733	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.100777	39,921	4,023	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.131421	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.268284	0	0	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	1.732026	0	0	55.01
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.171705	0	0	59.00
60.00	06000 LABORATORY	0.169254	112,068	18,968	60.00
60.01	06001 FSED LABORATORY	0.264681	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.147370	20,734	3,056	65.00
66.00	06600 PHYSICAL THERAPY	0.237369	11,622	2,759	66.00
69.00	06900 ELECTROCARDIOLOGY	0.141003	4,892	690	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.627174	5,589	3,505	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.383421	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.159809	221,724	35,433	73.00
76.00	03950 CV RESOURCE CENTER	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 OB CLINIC	0.000000	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0.000000	0	0	90.02
90.03	09003 INFUSION OP SERVICES	0.358825	0	0	90.03
90.04	09004 MATERNAL HEA	0.000000	0	0	90.04
91.00	09100 EMERGENCY	0.181383	107,148	19,435	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.448807	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.371999	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		523,698	87,869	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)		523,698		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150015 Component CCN: 15T015	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/26/2016 5:19 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		2,366,341		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.119567	95,784	11,453	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.779953	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.041733	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.100777	167,123	16,842	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.131421	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.268284	8,187	2,196	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	1.732026	0	0	55.01
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.171705	0	0	59.00
60.00	06000 LABORATORY	0.169254	265,687	44,969	60.00
60.01	06001 FSED LABORATORY	0.264681	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.147370	245,023	36,109	65.00
66.00	06600 PHYSICAL THERAPY	0.237369	2,613,563	620,379	66.00
69.00	06900 ELECTROCARDIOLOGY	0.141003	35,619	5,022	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.627174	107,804	67,612	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.383421	5,871	2,251	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.159809	627,995	100,359	73.00
76.00	03950 CV RESOURCE CENTER	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 OB CLINIC	0.000000	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0.000000	0	0	90.02
90.03	09003 INFUSION OP SERVICES	0.358825	0	0	90.03
90.04	09004 MATERNAL HEA	0.000000	0	0	90.04
91.00	09100 EMERGENCY	0.181383	0	0	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.448807	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.371999	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,172,656	907,192	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)		4,172,656		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/26/2016 5:19 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		5,534,634	30.00
31.00	03100	INTENSIVE CARE UNIT		910,274	31.00
40.00	04000	SUBPROVIDER - IPF		1,657,252	40.00
41.00	04100	SUBPROVIDER - IRF		226,458	41.00
43.00	04300	NURSERY		897,264	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.118808	5,808,998	690,155 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.779953	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.041218	277,246	11,428 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100777	2,301,241	231,912 54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0.131421	98,893	12,997 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.268284	255,934	68,663 55.00
55.01	05501	WOODLAND CANCER CARE CENTER	1.732026	261	452 55.01
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MRI	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.171340	1,412,265	241,977 59.00
60.00	06000	LABORATORY	0.168897	3,400,054	574,259 60.00
60.01	06001	FSED LABORATORY	0.264681	7,071	1,872 60.01
65.00	06500	RESPIRATORY THERAPY	0.147370	1,561,817	230,165 65.00
66.00	06600	PHYSICAL THERAPY	0.233706	249,407	58,288 66.00
69.00	06900	ELECTROCARDIOLOGY	0.141003	632,705	89,213 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.627174	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.383421	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159809	0	0 73.00
76.00	03950	CV RESOURCE CENTER	0.000000	0	0 76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	0 90.00
90.01	09001	OB CLINIC	0.000000	0	0 90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0 90.02
90.03	09003	INFUSION OP SERVICES	0.358825	126,549	45,409 90.03
90.04	09004	MATERNAL HEA	0.000000	0	0 90.04
91.00	09100	EMERGENCY	0.181241	1,598,819	289,772 91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0.448585	101,680	45,612 91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.371999	0	0 92.00
200.00		Total (sum of lines 50-94 and 96-98)		17,832,940	2,592,174 200.00
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)		17,832,940	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/26/2016 5:19 pm
		Title XVIII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		16,526,884	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,983,139	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)		323,373	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)		140.76	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.22	30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.31	31.00
32.00	Sum of lines 30 and 31		26.53	32.00
33.00	Allowable disproportionate share percentage (see instructions)		11.10	33.00
34.00	Disproportionate share adjustment (see instructions)		596,903	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/26/2016 5:19 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)		0.000157052	0.000151187	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,201,082	968,526	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		898,343	243,455	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,141,798		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		23,572,097		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		23,572,097		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,860,029		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see 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)		25,432,126		59.00
60.00	Primary payer payments		5,938		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		25,426,188		61.00
62.00	Deductibles billed to program beneficiaries		2,411,272		62.00
63.00	Coinurance billed to program beneficiaries		57,015		63.00
64.00	Allowable bad debts (see instructions)		403,336		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		262,168		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		75,205		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		23,220,069		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-6,005		70.93
70.94	HRR adjustment amount (see instructions)		-99,627		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/26/2016 5:19 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		23,114,437		71.00
71.01	Sequestration adjustment (see instructions)		462,289		71.01
72.00	Interim payments		22,432,367		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)		219,781		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1,289,094		75.00
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/26/2016 5:19 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,612	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		19,175,644	2.00
3.00	PPS payments		18,908,743	3.00
4.00	Outlier payment (see instructions)		29,082	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)		8,612	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		53,856	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)		53,856	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		53,856	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		45,244	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)		8,612	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)		18,937,825	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,870,147	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)		15,076,290	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)		15,076,290	30.00
31.00	Primary payer payments		12,339	31.00
32.00	Subtotal (line 30 minus line 31)		15,063,951	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		808,603	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		525,592	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		435,929	36.00
37.00	Subtotal (see instructions)		15,589,543	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		15,589,543	40.00
40.01	Sequestration adjustment (see instructions)		311,791	40.01
41.00	Interim payments		15,128,119	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		149,633	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150015

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

Worksheet E-1
Part I
Date/Time Prepared:
5/26/2016 5:19 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		22,432,367		15,081,019	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0	07/17/2015	47,100	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		47,100	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		22,432,367		15,128,119	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		219,781		149,633	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		22,652,148		15,277,752	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150015
Component CCN: 15S015

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

Worksheet E-1
Part I
Date/Time Prepared:
5/26/2016 5:19 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		530,110		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		530,110		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		18,642		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		548,752		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150015
Component CCN: 15T015

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

Worksheet E-1
Part I
Date/Time Prepared:
5/26/2016 5:19 pm

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,517,871		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,517,871		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		21,775		0	6.02
7.00	Total Medicare program liability (see instructions)		2,496,096		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 150015

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

Worksheet E-1
Part II
Date/Time Prepared:
5/26/2016 5:19 pm

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			6,149 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			10,815 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1,334 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			19,367 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			554,949,183 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			33,397,239 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,001,250 8.00
9.00	Sequestration adjustment amount (see instructions)			20,025 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			981,225 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			937,191 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			44,034 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015 Component CCN: 15S015	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part II Date/Time Prepared: 5/26/2016 5:19 pm
		Title XVII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			597,909 1.00
2.00	Net IPF PPS Outlier Payments			32,024 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			7.786301 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			629,933 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			629,933 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			629,933 18.00
19.00	Deductibles			76,816 19.00
20.00	Subtotal (line 18 minus line 19)			553,117 20.00
21.00	Coinsurance			12,175 21.00
22.00	Subtotal (line 20 minus line 21)			540,942 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			29,244 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			19,009 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			253 25.00
26.00	Subtotal (sum of lines 22 and 24)			559,951 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			559,951 31.00
31.01	Sequestration adjustment (see instructions)			11,199 31.01
32.00	Interim payments			530,110 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			18,642 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			32,024 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015 Component CCN: 15T015	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part III Date/Time Prepared: 5/26/2016 5:19 pm
		Title XVIIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			2,453,363 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0101 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			36,064 3.00
4.00	Outlier Payments			78,487 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			7.506849 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			2,567,914 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			2,567,914 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			2,567,914 19.00
20.00	Deductibles			7,515 20.00
21.00	Subtotal (line 19 minus line 20)			2,560,399 21.00
22.00	Coinsurance			16,380 22.00
23.00	Subtotal (line 21 minus line 22)			2,544,019 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			4,643 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			3,018 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			2,547,037 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			2,547,037 32.00
32.01	Sequestration adjustment (see instructions)			50,941 32.01
33.00	Interim payments			2,517,871 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)			-21,775 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			78,487 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2016 5:19 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		17,832,940	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		17,832,940	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		17,832,940	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		17,832,940	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015 Component CCN: 15S015	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2016 5:19 pm
		Title XIX	Subprovider - IPF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015 Component CCN: 15T015	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2016 5:19 pm
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 150015

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

Worksheet G

Date/Time Prepared:
5/26/2016 5:19 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	84,866,571	0	0	0	1.00
2.00	Temporary investments	5,643,441	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	28,295,650	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,089,736	0	0	0	6.00
7.00	Inventory	3,678,008	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	2,613,508	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)	116,007,442	0	0	0	11.00
FIXED ASSETS						
12.00	Land	7,180,112	0	0	0	12.00
13.00	Land improvements	4,035,217	0	0	0	13.00
14.00	Accumulated depreciation	-2,299,426	0	0	0	14.00
15.00	Buildings	92,807,720	0	0	0	15.00
16.00	Accumulated depreciation	-48,427,733	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	113,763,381	0	0	0	23.00
24.00	Accumulated depreciation	-65,861,583	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)	101,197,688	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	-160,286	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	2,981,275	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,820,989	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	220,026,119	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	8,787,776	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,828,462	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	1,391,828	0	0	0	43.00
44.00	Other current liabilities	2,706,357	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	16,714,423	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	291,276	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,794,367	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,085,643	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	20,800,066	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	199,226,053				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)	199,226,053	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	220,026,119	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150015

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

Worksheet G-1

Date/Time Prepared:
5/26/2016 5:19 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		195,889,805		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		13,392,034				2.00
3.00	Total (sum of line 1 and line 2)		209,281,839		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		209,281,839		0		11.00
12.00	FUND BALANCE ADJ	10,055,783		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		10,055,783		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		199,226,056		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	FUND BALANCE ADJ		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: 150015

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/26/2016 5:19 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	29,826,312		29,826,312	1.00
2.00	SUBPROVIDER - IPF	3,599,673		3,599,673	2.00
3.00	SUBPROVIDER - IRF	6,696,022		6,696,022	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	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	40,122,007		40,122,007	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,674,010		5,674,010	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)	5,674,010		5,674,010	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	45,796,017		45,796,017	17.00
18.00	Ancillary services	137,661,084	315,096,756	452,757,840	18.00
19.00	Outpatient services	11,108,599	45,286,727	56,395,326	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	NON REIMBURSABLE	0	2,736,613	2,736,613	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	194,565,700	363,120,096	557,685,796	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		149,950,516		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)		149,950,516		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150015

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

Worksheet G-3

Date/Time Prepared:
5/26/2016 5:19 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	557,685,796	1.00
2.00	Less contractual allowances and discounts on patients' accounts	389,297,103	2.00
3.00	Net patient revenues (line 1 minus line 2)	168,388,693	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	149,950,516	4.00
5.00	Net income from service to patients (line 3 minus line 4)	18,438,177	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	25,591	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	643,291	10.00
11.00	Rebates and refunds of expenses	6,950	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	608,158	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	7,810	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	18,068	21.00
22.00	Rental of hospital space	300,459	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	614,302	24.00
24.01	PREMIUM REVENUE	7,257,432	24.01
25.00	Total other income (sum of lines 6-24)	9,482,061	25.00
26.00	Total (line 5 plus line 25)	27,920,238	26.00
27.00	BAD DEBTS	3,772,745	27.00
27.01	EQUITY TRANSFERS	10,838,676	27.01
27.02	NON OPERATING REVENUE	-5,138	27.02
27.03	CONTRIBUTION OF PPE	-106,072	27.03
27.04	MINORITY INTEREST	27,993	27.04
28.00	Total other expenses (sum of line 27 and subscripts)	14,528,204	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	13,392,034	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150015	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/26/2016 5:19 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,713,505	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		51,939	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)		56.82	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)		4.22	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		22.31	8.00
9.00	Sum of lines 7 and 8		26.53	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.52	10.00
11.00	Disproportionate share adjustment (see instructions)		94,585	11.00
12.00	Total prospective capital payments (see instructions)		1,860,029	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00