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: 151317	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/26/2016 8:30 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/26/2016 Time: 8:30 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GREENE COUNTY GENERAL HOSPITAL (151317) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	188,375	-639,495	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-38,640	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	149,735	-639,495	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2016 8:27 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street:R.R 1	PO Box:1000			1.00
2.00	City: LINTON	State: IN	Zip Code: 47441-9457	County: GREENE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	GREENE COUNTY GENERAL HOSPITAL	151317	99915	1	02/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GREENE COUNTY GENERAL HOSPITAL	15Z317	99915		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2015	12/31/2015	20.00
21.00	Type of Control (see instructions)	9		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.	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 8:27 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
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	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	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: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 8:27 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 8:27 am

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	94,937	0	0	118.01

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

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		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151317	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 8:27 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2016 8:27 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	04/07/2016	Y 16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N 18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N 19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N 20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2016 8:27 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		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.	RENEE	ESSLINGER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-383-4000	RESSLINGER@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2016 8:27 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	04/07/2016			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		SENIOR MANAGER		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: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2016 8:27 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	20	7,300	55,536.00	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)		20	7,300	55,536.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	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)		25	9,125	55,536.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				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: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2016 8:27 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,244	42	1,860			1.00
2.00	HMO and other (see instructions)	91	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	542	0	542			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,786	42	2,402			7.00
8.00	INTENSIVE CARE UNIT	308	19	373			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		88	136			13.00
14.00	Total (see instructions)	2,094	149	2,911	0.00	240.97	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	240.97	27.00
28.00	Observation Bed Days		212	1,079			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	38	38			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: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2016 8:27 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	492	63	782	1.00
2.00	HMO and other (see instructions)			26	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	492	63	782	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-10 | Date/Time Prepared: 5/26/2016 8:27 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.364329	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,050,128	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,397,802	5.00
6.00	Medicaid charges	7,312,517	6.00
7.00	Medicaid cost (line 1 times line 6)	2,664,162	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	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)	0	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	192,517	49,274	241,791	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	70,140	17,952	88,092	21.00
22.00	Partial payment by patients approved for charity care	2,216	8,624	10,840	22.00
23.00	Cost of charity care (line 21 minus line 22)	67,924	9,328	77,252	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)	0	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	539,507	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	-539,507	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	-196,558	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	-119,306	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	-119,306	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/26/2016 8:27 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		967,931	967,931	42,319	1,010,250	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		408,514	408,514	1,909	410,423	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,950,984	2,950,984	-285,147	2,665,837	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,510,306	2,671,526	4,181,832	-210,339	3,971,493	5.00
7.00	00700	OPERATION OF PLANT	421,486	1,139,813	1,561,299	0	1,561,299	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	217,617	217,617	0	217,617	8.00
9.00	00900	HOUSEKEEPING	336,512	105,670	442,182	0	442,182	9.00
10.00	01000	DIETARY	502,646	518,026	1,020,672	-887,986	132,686	10.00
11.00	01100	CAFETERIA	0	0	0	887,986	887,986	11.00
13.00	01300	NURSING ADMINISTRATION	690,681	152,519	843,200	0	843,200	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	86,881	86,881	0	86,881	14.00
15.00	01500	PHARMACY	497,472	45,076	542,548	0	542,548	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	230,245	16,040	246,285	0	246,285	16.00
17.00	01700	SOCIAL SERVICE	160,183	0	160,183	0	160,183	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	458,272	458,272	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,322,903	694,960	3,017,863	66,562	3,084,425	30.00
31.00	03100	INTENSIVE CARE UNIT	776,706	49,550	826,256	0	826,256	31.00
43.00	04300	NURSERY	10,067	127	10,194	0	10,194	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	388,855	608,406	997,261	-427,483	569,778	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,680	10,680	23,688	34,368	52.00
53.00	05300	ANESTHESIOLOGY	30,789	9,063	39,852	-30,789	9,063	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	773,057	392,181	1,165,238	0	1,165,238	54.00
60.00	06000	LABORATORY	808,544	1,227,076	2,035,620	0	2,035,620	60.00
65.00	06500	RESPIRATORY THERAPY	435,338	36,158	471,496	0	471,496	65.00
66.00	06600	PHYSICAL THERAPY	301,178	12,246	313,424	0	313,424	66.00
67.00	06700	OCCUPATIONAL THERAPY	94,685	91	94,776	0	94,776	67.00
68.00	06800	SPEECH PATHOLOGY	44,371	88	44,459	0	44,459	68.00
69.00	06900	ELECTROCARDIOLOGY	20,615	19,386	40,001	0	40,001	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	526,413	526,413	-2,695	523,718	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,695	2,695	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	258,103	1,180,515	1,438,618	0	1,438,618	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	945,630	663,321	1,608,951	0	1,608,951	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,560,372	14,710,858	26,271,230	-361,008	25,910,222	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	361,008	361,008	194.00
200.00		TOTAL (SUM OF LINES 118-199)	11,560,372	14,710,858	26,271,230	0	26,271,230	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/26/2016 8:27 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-28,245	982,005		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-209,916	200,507		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,665,837		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-698,804	3,272,689		5.00
7.00	00700	OPERATION OF PLANT	0	1,561,299		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	217,617		8.00
9.00	00900	HOUSEKEEPING	0	442,182		9.00
10.00	01000	DIETARY	0	132,686		10.00
11.00	01100	CAFETERIA	-320,830	567,156		11.00
13.00	01300	NURSING ADMINISTRATION	0	843,200		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	86,881		14.00
15.00	01500	PHARMACY	0	542,548		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,100	240,185		16.00
17.00	01700	SOCIAL SERVICE	0	160,183		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	458,272		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-585,053	2,499,372		30.00
31.00	03100	INTENSIVE CARE UNIT	0	826,256		31.00
43.00	04300	NURSERY	0	10,194		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	569,778		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	34,368		52.00
53.00	05300	ANESTHESIOLOGY	0	9,063		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,165,238		54.00
60.00	06000	LABORATORY	-31,554	2,004,066		60.00
65.00	06500	RESPIRATORY THERAPY	0	471,496		65.00
66.00	06600	PHYSICAL THERAPY	-703	312,721		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	94,776		67.00
68.00	06800	SPEECH PATHOLOGY	0	44,459		68.00
69.00	06900	ELECTROCARDIOLOGY	0	40,001		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	523,718		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,695		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,438,618		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	1,608,951		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,881,205	24,029,017		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	FOUNDATION / MOBS	0	361,008		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-1,881,205	24,390,025		200.00

RECLASSIFICATIONS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/26/2016 8:27 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CRNA RECLASS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	30,789	427,483	1.00
2.00		0.00	0	0	2.00
	0		30,789	427,483	
	B - LABOR & DELIVERY				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	23,688	0	1.00
	0		23,688	0	
	C - DIETARY RECLASS				
1.00	CAFETERIA	11.00	437,303	450,683	1.00
	0		437,303	450,683	
	E - INSURANCE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	42,319	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,909	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	75,861	3.00
	0		0	120,089	
	F - OB ON CALL RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	0	90,250	1.00
	0		0	90,250	
	G - IMPLANTABLE DEVICE RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,695	1.00
	0		0	2,695	
	H - RELATED PARTIES RECLASS				
1.00	FOUNDATION / MOBS	194.00	0	361,008	1.00
	0		0	361,008	
500.00	Grand Total: Increases		491,780	1,452,208	500.00

RECLASSIFICATIONS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/26/2016 8:27 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CRNA RECLASS						
1.00	OPERATING ROOM	50.00	0	427,483	0		1.00
2.00	ANESTHESIOLOGY	53.00	30,789	0	0		2.00
	0		30,789	427,483			
	B - LABOR & DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	23,688	0	0		1.00
	0		23,688	0			
	C - DIETARY RECLASS						
1.00	DIETARY	10.00	437,303	450,683	0		1.00
	0		437,303	450,683			
	E - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	120,089	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	0		3.00
	0		0	120,089			
	F - OB ON CALL RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	90,250	0		1.00
	0		0	90,250			
	G - IMPLANTABLE DEVICE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,695	0		1.00
	0		0	2,695			
	H - RELATED PARTIES RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	361,008	0		1.00
	0		0	361,008			
500.00	Grand Total: Decreases		491,780	1,452,208			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I Date/Time Prepared: 5/26/2016 8:27 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	759,198	0	0	0	108,000	1.00
2.00	Land Improvements	381,772	6,500	0	6,500	52,543	2.00
3.00	Buildings and Fixtures	7,300,878	5,980	0	5,980	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,756,983	18,081	0	18,081	2,483	5.00
6.00	Movable Equipment	2,381,901	46,060	0	46,060	278,792	6.00
7.00	HIT designated Assets	867,152	195,236	0	195,236	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,447,884	271,857	0	271,857	441,818	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	14,447,884	271,857	0	271,857	441,818	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	651,198	0	1.00
2.00	Land Improvements	335,729	0	2.00
3.00	Buildings and Fixtures	7,306,858	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,772,581	0	5.00
6.00	Movable Equipment	2,149,169	0	6.00
7.00	HIT designated Assets	1,062,388	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,277,923	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	14,277,923	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/26/2016 8:27 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	579,674	0	345,938	42,319	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	406,605	0	0	1,909	0	2.00
3.00	Total (sum of lines 1-2)	986,279	0	345,938	44,228	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	967,931	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	408,514	2.00
3.00	Total (sum of lines 1-2)	0	1,376,445	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2016 8:27 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	11,917,920	0	11,917,920	0.833431	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,381,901	0	2,381,901	0.166569	0	2.00
3.00	Total (sum of lines 1-2)	14,299,821	0	14,299,821	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	551,429	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	196,689	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	748,118	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	345,938	84,638	0	0	982,005	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,818	0	0	200,507	2.00
3.00	Total (sum of lines 1-2)	345,938	88,456	0	0	1,182,512	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/26/2016 8:27 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-8,849	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-1,053	ADULTS & PEDIATRICS	30.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,159	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-615,554			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-320,830	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,100	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-209,916	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CPR TRAINING	B	-540	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISC REVENUE - ADMIN	B	-871	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/26/2016 8:27 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	AHA DUES	A	-2,050	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	IHA DUES	A	-505	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MARKETING & ADVERTISING	A	-75,673	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	RENTAL OF PROVIDER SPACE - BENEFITS	B	-44,133	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.06	GIFT CARD USAGE	B	-6,247	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	THERAPY REVENUE	B	-703	PHYSICAL THERAPY	66.00	0	33.07
33.08	FLOWERS	A	-285	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	BOND INTEREST	A	-8,102	CAP REL COSTS-BLDG & FIXT	1.00	9	33.09
33.10	VOLUNTEER RECOGNITION	A	-467	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	SCHOLARSHIP WINNER PAYMENT	A	-500	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	HOSPITAL ASSESSMENT FEE	A	-600,658	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	BOND AMORTIZATION EXPENSE ADJUSTMENT	A	23,990	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,881,205				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2016 8:27 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	31,554	31,554	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	584,000	584,000	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			615,554	615,554	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	31,554		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	584,000		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	615,554		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/26/2016 8:27 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	982,005	982,005				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	200,507		200,507			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,665,837	0	0	2,665,837		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,272,689	75,722	15,461	348,278	3,712,150	5.00
7.00	00700	OPERATION OF PLANT	1,561,299	124,009	25,320	97,195	1,807,823	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	217,617	6,606	1,349	0	225,572	8.00
9.00	00900	HOUSEKEEPING	442,182	7,309	1,492	77,600	528,583	9.00
10.00	01000	DIETARY	132,686	34,504	7,045	15,068	189,303	10.00
11.00	01100	CAFETERIA	567,156	37,901	7,739	100,843	713,639	11.00
13.00	01300	NURSING ADMINISTRATION	843,200	4,749	970	159,272	1,008,191	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	86,881	42,610	8,700	0	138,191	14.00
15.00	01500	PHARMACY	542,548	21,225	4,334	114,718	682,825	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	240,185	14,141	2,887	53,095	310,308	16.00
17.00	01700	SOCIAL SERVICE	160,183	3,794	775	36,938	201,690	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	458,272	0	0	7,100	465,372	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,499,372	158,433	32,349	530,206	3,220,360	30.00
31.00	03100	INTENSIVE CARE UNIT	826,256	35,552	7,259	179,109	1,048,176	31.00
43.00	04300	NURSERY	10,194	6,766	1,381	2,321	20,662	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	569,778	103,553	21,144	89,670	784,145	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,368	83,509	17,051	5,462	140,390	52.00
53.00	05300	ANESTHESIOLOGY	9,063	0	0	0	9,063	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,165,238	60,413	12,335	178,268	1,416,254	54.00
60.00	06000	LABORATORY	2,004,066	24,741	5,052	186,451	2,220,310	60.00
65.00	06500	RESPIRATORY THERAPY	471,496	6,792	1,387	100,389	580,064	65.00
66.00	06600	PHYSICAL THERAPY	312,721	8,424	1,720	69,452	392,317	66.00
67.00	06700	OCCUPATIONAL THERAPY	94,776	8,424	1,720	21,834	126,754	67.00
68.00	06800	SPEECH PATHOLOGY	44,459	8,424	1,720	10,232	64,835	68.00
69.00	06900	ELECTROCARDIOLOGY	40,001	3,622	739	4,754	49,116	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	523,718	0	0	0	523,718	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,695	0	0	0	2,695	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,438,618	10,666	2,178	59,519	1,510,981	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,608,951	75,324	15,380	218,063	1,917,718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,029,017	967,213	197,487	2,665,837	24,011,205	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,688	753	0	4,441	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,104	2,267	0	13,371	192.00
194.00	07950	FOUNDATION / MOBS	361,008	0	0	0	361,008	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24,390,025	982,005	200,507	2,665,837	24,390,025	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/26/2016 8:27 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,712,150					5.00
7.00	00700	OPERATION OF PLANT	324,546	2,132,369				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	40,495	18,008	284,075			8.00
9.00	00900	HOUSEKEEPING	94,893	19,925	0	643,401		9.00
10.00	01000	DIETARY	33,984	94,054	0	0	317,341	10.00
11.00	01100	CAFETERIA	128,115	103,312	0	267	0	11.00
13.00	01300	NURSING ADMINISTRATION	180,993	12,946	0	1,203	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	24,808	116,149	1,726	9,624	0	14.00
15.00	01500	PHARMACY	122,583	57,857	0	4,946	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55,707	38,547	0	535	0	16.00
17.00	01700	SOCIAL SERVICE	36,208	10,342	0	267	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	83,545	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	578,128	431,869	77,922	210,073	274,361	30.00
31.00	03100	INTENSIVE CARE UNIT	188,172	96,911	26,264	74,320	42,980	31.00
43.00	04300	NURSERY	3,709	18,442	0	2,807	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	140,772	282,272	18,211	55,954	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,203	227,633	11,587	9,089	0	52.00
53.00	05300	ANESTHESIOLOGY	1,627	0	0	4,144	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	254,250	164,676	40,054	43,710	0	54.00
60.00	06000	LABORATORY	398,597	67,440	0	25,932	0	60.00
65.00	06500	RESPIRATORY THERAPY	104,135	18,514	0	8,287	0	65.00
66.00	06600	PHYSICAL THERAPY	70,430	22,962	42,864	17,912	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,755	22,962	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,639	22,962	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,817	9,872	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	94,019	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	484	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	271,256	29,073	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	344,274	205,321	53,120	143,961	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,644,144	2,092,049	271,748	613,031	317,341	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	797	10,053	0	535	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,400	30,267	12,327	26,948	0	192.00
194.00	07950	FOUNDATION / MOBS	64,809	0	0	2,887	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,712,150	2,132,369	284,075	643,401	317,341	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/26/2016 8:27 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	945,333					11.00
13.00	01300	NURSING ADMINISTRATION	44,863	1,248,196				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	290,498			14.00
15.00	01500	PHARMACY	37,777	0	0	905,988		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,548	0	0	0	438,645	16.00
17.00	01700	SOCIAL SERVICE	11,430	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,143	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	271,410	637,043	0	0	39,992	30.00
31.00	03100	INTENSIVE CARE UNIT	71,496	167,812	0	0	15,870	31.00
43.00	04300	NURSERY	0	0	0	0	3,174	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	105,215	246,956	0	0	20,440	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	4,571	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,611	0	0	0	16,632	54.00
60.00	06000	LABORATORY	104,643	0	0	0	27,296	60.00
65.00	06500	RESPIRATORY THERAPY	42,463	0	0	0	2,031	65.00
66.00	06600	PHYSICAL THERAPY	31,204	0	0	0	5,078	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,916	0	0	0	3,174	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,650	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	5,332	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	289,026	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,472	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,945	0	0	905,988	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	83,669	196,385	0	0	293,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	945,333	1,248,196	290,498	905,988	438,645	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	945,333	1,248,196	290,498	905,988	438,645	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/26/2016 8:27 am

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	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
17.00	01700	SOCIAL SERVICE	259,937					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	550,060				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	166,359	0	5,907,517	0	5,907,517	30.00
31.00	03100	INTENSIVE CARE UNIT	65,851	0	1,797,852	0	1,797,852	31.00
43.00	04300	NURSERY	3,466	0	52,260	0	52,260	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	1,653,965	0	1,653,965	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	418,473	0	418,473	52.00
53.00	05300	ANESTHESIOLOGY	0	550,060	564,894	0	564,894	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,017,187	0	2,017,187	54.00
60.00	06000	LABORATORY	0	0	2,844,218	0	2,844,218	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	755,494	0	755,494	65.00
66.00	06600	PHYSICAL THERAPY	0	0	582,767	0	582,767	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	184,561	0	184,561	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	101,086	0	101,086	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	73,137	0	73,137	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	906,763	0	906,763	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,651	0	4,651	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,733,243	0	2,733,243	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	24,261	0	3,262,114	0	3,262,114	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	259,937	550,060	23,860,182	0	23,860,182	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	15,826	0	15,826	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	85,313	0	85,313	192.00
194.00	07950	FOUNDATION / MOBS	0	0	428,704	0	428,704	194.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	259,937	550,060	24,390,025	0	24,390,025	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/26/2016 8:27 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	75,722	15,461	91,183	0	5.00
7.00	00700	OPERATION OF PLANT	0	124,009	25,320	149,329	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,606	1,349	7,955	0	8.00
9.00	00900	HOUSEKEEPING	0	7,309	1,492	8,801	0	9.00
10.00	01000	DIETARY	0	34,504	7,045	41,549	0	10.00
11.00	01100	CAFETERIA	0	37,901	7,739	45,640	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,749	970	5,719	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	42,610	8,700	51,310	0	14.00
15.00	01500	PHARMACY	0	21,225	4,334	25,559	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,141	2,887	17,028	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,794	775	4,569	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	158,433	32,349	190,782	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	35,552	7,259	42,811	0	31.00
43.00	04300	NURSERY	0	6,766	1,381	8,147	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	103,553	21,144	124,697	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	83,509	17,051	100,560	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	60,413	12,335	72,748	0	54.00
60.00	06000	LABORATORY	0	24,741	5,052	29,793	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,792	1,387	8,179	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,424	1,720	10,144	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,424	1,720	10,144	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,424	1,720	10,144	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,622	739	4,361	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	10,666	2,178	12,844	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	75,324	15,380	90,704	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	967,213	197,487	1,164,700	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,688	753	4,441	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,104	2,267	13,371	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	982,005	200,507	1,182,512	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/26/2016 8:27 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	91,183					5.00
7.00	00700	OPERATION OF PLANT	7,972	157,301				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	995	1,328	10,278			8.00
9.00	00900	HOUSEKEEPING	2,331	1,470	0	12,602		9.00
10.00	01000	DIETARY	835	6,938	0	0	49,322	10.00
11.00	01100	CAFETERIA	3,147	7,621	0	5	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,446	955	0	24	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	609	8,568	62	189	0	14.00
15.00	01500	PHARMACY	3,011	4,268	0	97	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,368	2,844	0	10	0	16.00
17.00	01700	SOCIAL SERVICE	889	763	0	5	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	2,052	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,197	31,857	2,820	4,114	42,642	30.00
31.00	03100	INTENSIVE CARE UNIT	4,622	7,149	950	1,456	6,680	31.00
43.00	04300	NURSERY	91	1,360	0	55	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,458	20,823	659	1,096	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	619	16,792	419	178	0	52.00
53.00	05300	ANESTHESIOLOGY	40	0	0	81	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,246	12,148	1,449	856	0	54.00
60.00	06000	LABORATORY	9,792	4,975	0	508	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,558	1,366	0	162	0	65.00
66.00	06600	PHYSICAL THERAPY	1,730	1,694	1,551	351	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	559	1,694	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	286	1,694	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	217	728	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,310	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,663	2,145	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,457	15,146	1,922	2,820	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	89,512	154,326	9,832	12,007	49,322	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20	742	0	10	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59	2,233	446	528	0	192.00
194.00	07950	FOUNDATION / MOBS	1,592	0	0	57	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	91,183	157,301	10,278	12,602	49,322	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/26/2016 8:27 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	56,413					11.00
13.00	01300	NURSING ADMINISTRATION	2,677	13,821				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	60,738			14.00
15.00	01500	PHARMACY	2,254	0	0	35,189		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,002	0	0	0	23,252	16.00
17.00	01700	SOCIAL SERVICE	682	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	68	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,196	7,054	0	0	2,120	30.00
31.00	03100	INTENSIVE CARE UNIT	4,267	1,858	0	0	841	31.00
43.00	04300	NURSERY	0	0	0	0	168	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,279	2,734	0	0	1,084	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	242	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,870	0	0	0	882	54.00
60.00	06000	LABORATORY	6,245	0	0	0	1,447	60.00
65.00	06500	RESPIRATORY THERAPY	2,534	0	0	0	108	65.00
66.00	06600	PHYSICAL THERAPY	1,862	0	0	0	269	66.00
67.00	06700	OCCUPATIONAL THERAPY	532	0	0	0	168	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	87	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	283	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	60,430	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	308	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	952	0	0	35,189	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,993	2,175	0	0	15,553	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	56,413	13,821	60,738	35,189	23,252	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	56,413	13,821	60,738	35,189	23,252	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/26/2016 8:27 am

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	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
17.00	01700	SOCIAL SERVICE	6,908					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	2,120				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,421		316,203	0	316,203	30.00
31.00	03100	INTENSIVE CARE UNIT	1,750		72,384	0	72,384	31.00
43.00	04300	NURSERY	92		9,913	0	9,913	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		160,830	0	160,830	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		118,810	0	118,810	52.00
53.00	05300	ANESTHESIOLOGY	0		121	0	121	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		99,199	0	99,199	54.00
60.00	06000	LABORATORY	0		52,760	0	52,760	60.00
65.00	06500	RESPIRATORY THERAPY	0		14,907	0	14,907	65.00
66.00	06600	PHYSICAL THERAPY	0		17,601	0	17,601	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		13,097	0	13,097	67.00
68.00	06800	SPEECH PATHOLOGY	0		12,211	0	12,211	68.00
69.00	06900	ELECTROCARDIOLOGY	0		5,589	0	5,589	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		62,740	0	62,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		320	0	320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		57,793	0	57,793	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	645		142,415	0	142,415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,908	0	1,156,893	0	1,156,893	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		5,213	0	5,213	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		16,637	0	16,637	192.00
194.00	07950	FOUNDATION / MOBS	0		1,649	0	1,649	194.00
200.00		Cross Foot Adjustments		2,120	2,120	0	2,120	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,908	2,120	1,182,512	0	1,182,512	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 8:27 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	74,025					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		74,025				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	11,560,372			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,708	5,708	1,510,306	-3,712,150	20,677,875	5.00
7.00	00700	OPERATION OF PLANT	9,348	9,348	421,486	0	1,807,823	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	498	498	0	0	225,572	8.00
9.00	00900	HOUSEKEEPING	551	551	336,512	0	528,583	9.00
10.00	01000	DIETARY	2,601	2,601	65,343	0	189,303	10.00
11.00	01100	CAFETERIA	2,857	2,857	437,303	0	713,639	11.00
13.00	01300	NURSING ADMINISTRATION	358	358	690,681	0	1,008,191	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,212	3,212	0	0	138,191	14.00
15.00	01500	PHARMACY	1,600	1,600	497,472	0	682,825	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,066	1,066	230,245	0	310,308	16.00
17.00	01700	SOCIAL SERVICE	286	286	160,183	0	201,690	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	30,789	0	465,372	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,943	11,943	2,299,215	0	3,220,360	30.00
31.00	03100	INTENSIVE CARE UNIT	2,680	2,680	776,706	0	1,048,176	31.00
43.00	04300	NURSERY	510	510	10,067	0	20,662	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,806	7,806	388,855	0	784,145	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,295	6,295	23,688	0	140,390	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	9,063	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,554	4,554	773,057	0	1,416,254	54.00
60.00	06000	LABORATORY	1,865	1,865	808,544	0	2,220,310	60.00
65.00	06500	RESPIRATORY THERAPY	512	512	435,338	0	580,064	65.00
66.00	06600	PHYSICAL THERAPY	635	635	301,178	0	392,317	66.00
67.00	06700	OCCUPATIONAL THERAPY	635	635	94,685	0	126,754	67.00
68.00	06800	SPEECH PATHOLOGY	635	635	44,371	0	64,835	68.00
69.00	06900	ELECTROCARDIOLOGY	273	273	20,615	0	49,116	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	523,718	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,695	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	804	804	258,103	0	1,510,981	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,678	5,678	945,630	0	1,917,718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	72,910	72,910	11,560,372	-3,712,150	20,299,055	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	278	278	0	0	4,441	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	837	837	0	0	13,371	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	361,008	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	982,005	200,507	2,665,837		3,712,150	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.265856	2.708639	0.230601		0.179523	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		91,183	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.004410	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 8:27 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PIECES OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	58,969					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	498	17,284				8.00
9.00	00900	HOUSEKEEPING	551	0	24,067			9.00
10.00	01000	DIETARY	2,601	0	0	8,262		10.00
11.00	01100	CAFETERIA	2,857	0	10	0	16,541	11.00
13.00	01300	NURSING ADMINISTRATION	358	0	45	0	785	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,212	105	360	0	0	14.00
15.00	01500	PHARMACY	1,600	0	185	0	661	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,066	0	20	0	587	16.00
17.00	01700	SOCIAL SERVICE	286	0	10	0	200	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	20	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,943	4,741	7,858	7,143	4,749	30.00
31.00	03100	INTENSIVE CARE UNIT	2,680	1,598	2,780	1,119	1,251	31.00
43.00	04300	NURSERY	510	0	105	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,806	1,108	2,093	0	1,841	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,295	705	340	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	155	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,554	2,437	1,635	0	1,428	54.00
60.00	06000	LABORATORY	1,865	0	970	0	1,831	60.00
65.00	06500	RESPIRATORY THERAPY	512	0	310	0	743	65.00
66.00	06600	PHYSICAL THERAPY	635	2,608	670	0	546	66.00
67.00	06700	OCCUPATIONAL THERAPY	635	0	0	0	156	67.00
68.00	06800	SPEECH PATHOLOGY	635	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	273	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	804	0	0	0	279	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,678	3,232	5,385	0	1,464	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	57,854	16,534	22,931	8,262	16,541	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	278	0	20	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	837	750	1,008	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	108	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,132,369	284,075	643,401	317,341	945,333	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.160847	16.435721	26.733743	38.409707	57.150898	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	157,301	10,278	12,602	49,322	56,413	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.667520	0.594654	0.523622	5.969741	3.410495	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 8:27 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		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	9,305					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	531,803				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	86,375		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	75	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,749	0	0	7,875	48	30.00
31.00	03100	INTENSIVE CARE UNIT	1,251	0	0	3,125	19	31.00
43.00	04300	NURSERY	0	0	0	625	1	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,841	0	0	4,025	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	900	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,275	0	54.00
60.00	06000	LABORATORY	0	0	0	5,375	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	400	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	625	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	325	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,050	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	529,108	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,695	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,464	0	0	57,775	7	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,305	531,803	100	86,375	75	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,248,196	290,498	905,988	438,645	259,937	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	134.142504	0.546251	9,059.880000	5.078379	3,465.826667	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,821	60,738	35,189	23,252	6,908	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.485330	0.114211	351.890000	0.269198	92.106667	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 8:27 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		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
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	FOUNDATION / MOBS	0	194.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	550,060	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5,500.600000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,120	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	21.200000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 8:27 am

Title XVIII | Hospital | Cost

		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	5,907,517		5,907,517	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,797,852		1,797,852	0	0	31.00
43.00	04300	NURSERY	52,260		52,260	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,653,965		1,653,965	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	418,473		418,473	0	0	52.00
53.00	05300	ANESTHESIOLOGY	564,894		564,894	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,017,187		2,017,187	0	0	54.00
60.00	06000	LABORATORY	2,844,218		2,844,218	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	755,494	0	755,494	0	0	65.00
66.00	06600	PHYSICAL THERAPY	582,767	0	582,767	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	184,561	0	184,561	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	101,086	0	101,086	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	73,137		73,137	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	906,763		906,763	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,651		4,651	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,733,243		2,733,243	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,262,114		3,262,114	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,831,149		1,831,149		0	92.00
200.00		Subtotal (see instructions)	25,691,331	0	25,691,331	0	0	200.00
201.00		Less Observation Beds	1,831,149		1,831,149		0	201.00
202.00		Total (see instructions)	23,860,182	0	23,860,182	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 8:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,430,449		2,430,449			30.00
31.00	03100	INTENSIVE CARE UNIT	947,072		947,072			31.00
43.00	04300	NURSERY	172,726		172,726			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	579,124	2,543,249	3,122,373	0.529714	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	163,603	93,530	257,133	1.627457	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	258,663	699,450	958,113	0.589590	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	622,910	13,459,634	14,082,544	0.143240	0.000000	54.00
60.00	06000	LABORATORY	950,485	10,622,054	11,572,539	0.245773	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	680,151	560,732	1,240,883	0.608836	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	180,849	1,704,842	1,885,691	0.309047	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	108,631	606,221	714,852	0.258181	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,407	188,899	205,306	0.492367	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	356,400	1,560,505	1,916,905	0.038154	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	919,174	1,022,048	1,941,222	0.467109	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	45,090	45,090	0.103149	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,971,937	6,262,522	8,234,459	0.331927	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	451,630	13,645,489	14,097,119	0.231403	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,666,291	1,666,291	1.098937	0.000000	92.00
200.00		Subtotal (see instructions)	10,810,211	54,680,556	65,490,767			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,810,211	54,680,556	65,490,767			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 8:27 am

Title XVIII | 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
43.00	04300	NURSERY		43.00
		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
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 8:27 am

Title XIX | Hospital | Cost

		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	5,907,517		5,907,517	0	5,907,517	30.00
31.00	03100	INTENSIVE CARE UNIT	1,797,852		1,797,852	0	1,797,852	31.00
43.00	04300	NURSERY	52,260		52,260	0	52,260	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,653,965		1,653,965	0	1,653,965	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	418,473		418,473	0	418,473	52.00
53.00	05300	ANESTHESIOLOGY	564,894		564,894	0	564,894	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,017,187		2,017,187	0	2,017,187	54.00
60.00	06000	LABORATORY	2,844,218		2,844,218	0	2,844,218	60.00
65.00	06500	RESPIRATORY THERAPY	755,494	0	755,494	0	755,494	65.00
66.00	06600	PHYSICAL THERAPY	582,767	0	582,767	0	582,767	66.00
67.00	06700	OCCUPATIONAL THERAPY	184,561	0	184,561	0	184,561	67.00
68.00	06800	SPEECH PATHOLOGY	101,086	0	101,086	0	101,086	68.00
69.00	06900	ELECTROCARDIOLOGY	73,137		73,137	0	73,137	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	906,763		906,763	0	906,763	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,651		4,651	0	4,651	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,733,243		2,733,243	0	2,733,243	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,262,114		3,262,114	0	3,262,114	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,831,149		1,831,149		1,831,149	92.00
200.00		Subtotal (see instructions)	25,691,331	0	25,691,331	0	25,691,331	200.00
201.00		Less Observation Beds	1,831,149		1,831,149		1,831,149	201.00
202.00		Total (see instructions)	23,860,182	0	23,860,182	0	23,860,182	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 8:27 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,430,449		2,430,449			30.00
31.00	03100	INTENSIVE CARE UNIT	947,072		947,072			31.00
43.00	04300	NURSERY	172,726		172,726			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	579,124	2,543,249	3,122,373	0.529714	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	163,603	93,530	257,133	1.627457	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	258,663	699,450	958,113	0.589590	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	622,910	13,459,634	14,082,544	0.143240	0.000000	54.00
60.00	06000	LABORATORY	950,485	10,622,054	11,572,539	0.245773	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	680,151	560,732	1,240,883	0.608836	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	180,849	1,704,842	1,885,691	0.309047	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	108,631	606,221	714,852	0.258181	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,407	188,899	205,306	0.492367	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	356,400	1,560,505	1,916,905	0.038154	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	919,174	1,022,048	1,941,222	0.467109	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	45,090	45,090	0.103149	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,971,937	6,262,522	8,234,459	0.331927	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	451,630	13,645,489	14,097,119	0.231403	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,666,291	1,666,291	1.098937	0.000000	92.00
200.00		Subtotal (see instructions)	10,810,211	54,680,556	65,490,767			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,810,211	54,680,556	65,490,767			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 8:27 am

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
43.00	04300	NURSERY			43.00
		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
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
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 ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/26/2016 8:27 am

Title XVIII | Hospital | Cost

		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	160,830	3,122,373	0.051509	154,397	7,953	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	118,810	257,133	0.462057	0	0	52.00
53.00	05300	ANESTHESIOLOGY	121	958,113	0.000126	40,847	5	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,199	14,082,544	0.007044	448,170	3,157	54.00
60.00	06000	LABORATORY	52,760	11,572,539	0.004559	591,845	2,698	60.00
65.00	06500	RESPIRATORY THERAPY	14,907	1,240,883	0.012013	337,314	4,052	65.00
66.00	06600	PHYSICAL THERAPY	17,601	1,885,691	0.009334	69,750	651	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,097	714,852	0.018321	30,610	561	67.00
68.00	06800	SPEECH PATHOLOGY	12,211	205,306	0.059477	11,097	660	68.00
69.00	06900	ELECTROCARDIOLOGY	5,589	1,916,905	0.002916	308,081	898	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	62,740	1,941,222	0.032320	43,764	1,414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	320	45,090	0.007097	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,793	8,234,459	0.007018	1,620,996	11,376	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	142,415	14,097,119	0.010102	6,177	62	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	116,088	1,666,291	0.069669	0	0	92.00
200.00		Total (lines 50-199)	874,481	61,940,520		3,663,048	33,487	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 8:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	550,060	0	0	0	550,060	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	550,060	0	0	0	550,060	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 8:27 am

Title XVIII | Hospital | Cost

		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	3,122,373	0.000000	0.000000	154,397	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	257,133	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	958,113	0.574108	0.000000	40,847	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,082,544	0.000000	0.000000	448,170	54.00
60.00	06000	LABORATORY	0	11,572,539	0.000000	0.000000	591,845	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,240,883	0.000000	0.000000	337,314	65.00
66.00	06600	PHYSICAL THERAPY	0	1,885,691	0.000000	0.000000	69,750	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	714,852	0.000000	0.000000	30,610	67.00
68.00	06800	SPEECH PATHOLOGY	0	205,306	0.000000	0.000000	11,097	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,916,905	0.000000	0.000000	308,081	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,941,222	0.000000	0.000000	43,764	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	45,090	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,234,459	0.000000	0.000000	1,620,996	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	14,097,119	0.000000	0.000000	6,177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,666,291	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	61,940,520			3,663,048	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 8:27 am

Title XVIII | Hospital | Cost

		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	23,451	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	23,451	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/26/2016 8:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.529714	0	866,802	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.627457	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.589590	0	172,725	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143240	0	4,708,711	0	0	54.00
60.00	06000	LABORATORY	0.245773	0	4,520,224	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.608836	0	177,894	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.309047	0	680,514	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.258181	0	249,939	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.492367	0	18,450	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038154	0	879,197	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.467109	0	386,538	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.103149	0	34,092	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331927	0	2,933,734	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.231403	0	4,098,493	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.098937	0	614,749	0	0	92.00
200.00		Subtotal (see instructions)		0	20,342,062	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	20,342,062	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/26/2016 8:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	459,157	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	101,837	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	674,476	0		54.00
60.00	06000	LABORATORY	1,110,949	0		60.00
65.00	06500	RESPIRATORY THERAPY	108,308	0		65.00
66.00	06600	PHYSICAL THERAPY	210,311	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	64,530	0		67.00
68.00	06800	SPEECH PATHOLOGY	9,084	0		68.00
69.00	06900	ELECTROCARDIOLOGY	33,545	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	180,555	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,517	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	973,786	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	948,404	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	675,570	0		92.00
200.00		Subtotal (see instructions)	5,554,029	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,554,029	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151317 | Component CCN: 15Z317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/26/2016 8:27 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.529714	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.627457	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.589590	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143240	0	0	0	0	54.00
60.00	06000	LABORATORY	0.245773	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.608836	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.309047	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.258181	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.492367	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038154	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.467109	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.103149	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331927	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.231403	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.098937	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151317 | Component CCN: 15Z317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/26/2016 8:27 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/26/2016 8:27 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.529714	0	85,806	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.627457	0	157	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.589590	0	23,599	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143240	0	454,110	0	0	54.00
60.00	06000	LABORATORY	0.245773	0	358,374	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.608836	0	21,917	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.309047	0	57,519	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.258181	0	20,453	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.492367	0	6,373	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038154	0	56,529	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.467109	0	36,004	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.103149	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331927	0	211,289	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.231403	0	460,381	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.098937	0	49,862	0	0	92.00
200.00		Subtotal (see instructions)		0	1,842,373	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	1,842,373	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/26/2016 8:27 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	45,453	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	256	0		52.00
53.00	05300	ANESTHESIOLOGY	13,914	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,047	0		54.00
60.00	06000	LABORATORY	88,079	0		60.00
65.00	06500	RESPIRATORY THERAPY	13,344	0		65.00
66.00	06600	PHYSICAL THERAPY	17,776	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,281	0		67.00
68.00	06800	SPEECH PATHOLOGY	3,138	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2,157	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,818	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,133	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	106,534	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	54,795	0		92.00
200.00		Subtotal (see instructions)	502,725	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	502,725	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 8:27 am

Title XVIII | Hospital | Cost

	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)	3,481	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,939	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,860	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	542	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)	1,244	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)	542	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	130.15	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)	5,907,517	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)	919,812	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,987,705	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)	4,987,705	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)	1,697.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,111,155	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)	2,111,155	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 8:27 am

Title XVIII | Hospital | Cost

	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	1,797,852	373	4,819.98	308	1,484,554	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,127,496	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,723,205	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)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	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)	919,812	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)	919,812	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,079	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,697.08	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,831,149	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 8:27 am

Title XVIII | Hospital | Cost

	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	316,203	4,987,705	0.063396	1,831,149	116,088	90.00
91.00	Nursing School cost	0	4,987,705	0.000000	1,831,149	0	91.00
92.00	Allied health cost	0	4,987,705	0.000000	1,831,149	0	92.00
93.00	All other Medical Education	0	4,987,705	0.000000	1,831,149	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 8:27 am

Title XIX | Hospital | Cost

	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)	3,481	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,939	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,860	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)	42	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)	136	15.00
16.00	Nursery days (title V or XIX only)	88	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	5,907,517	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)	5,907,517	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)	5,907,517	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)	2,010.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	84,422	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)	84,422	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 8:27 am

Title XIX | Hospital | Cost

	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)	52,260	136	384.26	88	33,815	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,797,852	373	4,819.98	19	91,580	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)	90,976	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	300,793	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)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,079	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,010.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,168,833	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 8:27 am

Title XIX | Hospital | Cost

	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	316,203	5,907,517	0.053526	2,168,833	116,089	90.00
91.00	Nursing School cost	0	5,907,517	0.000000	2,168,833	0	91.00
92.00	Allied health cost	0	5,907,517	0.000000	2,168,833	0	92.00
93.00	All other Medical Education	0	5,907,517	0.000000	2,168,833	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/26/2016 8:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,595,313		30.00
31.00	03100	INTENSIVE CARE UNIT		656,660		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.529714	154,397	81,786	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.627457	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.589590	40,847	24,083	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143240	448,170	64,196	54.00
60.00	06000	LABORATORY	0.245773	591,845	145,460	60.00
65.00	06500	RESPIRATORY THERAPY	0.608836	337,314	205,369	65.00
66.00	06600	PHYSICAL THERAPY	0.309047	69,750	21,556	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.258181	30,610	7,903	67.00
68.00	06800	SPEECH PATHOLOGY	0.492367	11,097	5,464	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038154	308,081	11,755	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.467109	43,764	20,443	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.103149	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331927	1,620,996	538,052	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.231403	6,177	1,429	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.098937	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,663,048	1,127,496	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)		3,663,048		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151317 | Component CCN: 15Z317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/26/2016 8:27 am

Title XVIII | Swing Beds - SNF | Cost

		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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.529714	387	205	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.627457	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.589590	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143240	35,882	5,140	54.00
60.00	06000	LABORATORY	0.245773	37,075	9,112	60.00
65.00	06500	RESPIRATORY THERAPY	0.608836	58,173	35,418	65.00
66.00	06600	PHYSICAL THERAPY	0.309047	99,041	30,608	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.258181	73,363	18,941	67.00
68.00	06800	SPEECH PATHOLOGY	0.492367	4,724	2,326	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038154	39,899	1,522	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.467109	70,071	32,731	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.103149	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331927	153,224	50,859	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.231403	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.098937	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		571,839	186,862	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)		571,839		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/26/2016 8:27 am

Title XIX | Hospital | Cost

		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		88,090		30.00
31.00	03100	INTENSIVE CARE UNIT		31,857		31.00
43.00	04300	NURSERY		5,810		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.529714	19,480	10,319	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.627457	3,936	6,406	52.00
53.00	05300	ANESTHESIOLOGY	0.589590	8,701	5,130	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143240	20,953	3,001	54.00
60.00	06000	LABORATORY	0.245773	31,971	7,858	60.00
65.00	06500	RESPIRATORY THERAPY	0.608836	24,445	14,883	65.00
66.00	06600	PHYSICAL THERAPY	0.309047	6,083	1,880	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.258181	3,654	943	67.00
68.00	06800	SPEECH PATHOLOGY	0.492367	552	272	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038154	8,120	310	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.467109	30,918	14,442	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.103149	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331927	66,330	22,017	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.231403	15,191	3,515	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.098937	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		240,334	90,976	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)		240,334		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151317	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/26/2016 8:27 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,554,029	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	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)	5,554,029	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,609,569	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	54,497	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,185,070	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,370,002	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,370,002	30.00
31.00	Primary payer payments	2,912	31.00
32.00	Subtotal (line 30 minus line 31)	2,367,090	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)	745,615	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	484,650	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	597,746	36.00
37.00	Subtotal (see instructions)	2,851,740	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,851,740	40.00
40.01	Sequestration adjustment (see instructions)	57,035	40.01
41.00	Interim payments	3,434,200	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-639,495	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: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2016 8:27 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,956,981		3,434,200	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	07/22/2015	98,600		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)		98,600		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)		4,055,581		3,434,200	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		188,375		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		639,495	6.02
7.00	Total Medicare program liability (see instructions)		4,243,956		2,794,705	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: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2016 8:27 am

Component CCN: 15Z317 | Title XVIII | Swing Beds - SNF | Cost

		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		1,128,778		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)		1,128,778		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		38,640		0	6.02
7.00	Total Medicare program liability (see instructions)		1,090,138		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: 151317	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/26/2016 8:27 am
	Title XVIII	Hospital	Cost

		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	782	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,552	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	91	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,233	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	65,490,767	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	241,791	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)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	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)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151317 Component CCN: 15Z317	Period: From 01/01/2015 To 12/31/2015	Worksheet E-2 Date/Time Prepared: 5/26/2016 8:27 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	929,010	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	188,731	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	542	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,117,741	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,117,741	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,117,741	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,355	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,112,386	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,112,386	0	19.00
19.01	Sequestration adjustment (see instructions)	22,248	0	19.01
20.00	Interim payments	1,128,778	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-38,640	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151317	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part V Date/Time Prepared: 5/26/2016 8:27 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,723,205	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	4,723,205	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,754,378	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	4,754,378	19.00
20.00	Deductibles (exclude professional component)	477,408	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,276,970	22.00
23.00	Coinsurance	1,260	23.00
24.00	Subtotal (line 22 minus line 23)	4,275,710	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	84,395	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	54,857	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	49,292	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,330,567	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	4,330,567	30.00
30.01	Sequestration adjustment (see instructions)	86,611	30.01
31.00	Interim payments	4,055,581	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	188,375	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151317	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2016 8:27 am
	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	300,793		1.00
2.00	Medical and other services		502,725	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	300,793	502,725	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)	300,793	502,725	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	125,757		8.00
9.00	Ancillary service charges	240,334	1,842,373	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)	366,091	1,842,373	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)	366,091	1,842,373	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	65,298	1,339,648	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)	300,793	502,725	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)	300,793	502,725	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)	300,793	502,725	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	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)	300,793	502,725	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	300,793	502,725	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)	300,793	502,725	40.00
41.00	Interim payments	300,793	502,725	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: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/26/2016 8:27 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	554,825	0	0	0	1.00
2.00	Temporary investments	1,128,501	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,749,538	0	0	0	4.00
5.00	Other receivable	-471,346	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	323,597	0	0	0	7.00
8.00	Prepaid expenses	1,584,627	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,869,742	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	651,198	0	0	0	12.00
13.00	Land improvements	335,729	0	0	0	13.00
14.00	Accumulated depreciation	-65,321	0	0	0	14.00
15.00	Buildings	7,306,858	0	0	0	15.00
16.00	Accumulated depreciation	-2,503,104	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	3,639,733	0	0	0	19.00
20.00	Accumulated depreciation	-722,141	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	2,344,405	0	0	0	23.00
24.00	Accumulated depreciation	-1,117,515	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)	9,869,842	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	864,669	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	45,953	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	910,622	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	18,650,206	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	819,688	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,454,748	0	0	0	38.00
39.00	Payroll taxes payable	123,660	0	0	0	39.00
40.00	Notes and loans payable (short term)	304,867	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,702,963	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,520,530	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	8,520,530	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	11,223,493	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	7,426,713				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)	7,426,713	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	18,650,206	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/26/2016 8:27 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		5,748,519		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,678,194				2.00
3.00	Total (sum of line 1 and line 2)		7,426,713		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)		7,426,713		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		7,426,713		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 151317 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2016 8:27 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,618,852		2,618,852	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,618,852		2,618,852	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	947,072		947,072	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)	947,072		947,072	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,565,924		3,565,924	17.00
18.00	Ancillary services	7,317,735	54,610,978	61,928,713	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,883,659	54,610,978	65,494,637	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,271,230		29.00
30.00	BAD DEBT NOT ON WORKSHEET A	5,518,453			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)		5,518,453		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		31,789,683		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151317	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prepared: 5/26/2016 8:27 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	65,494,637	1.00
2.00	Less contractual allowances and discounts on patients' accounts	33,671,772	2.00
3.00	Net patient revenues (line 1 minus line 2)	31,822,865	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,789,683	4.00
5.00	Net income from service to patients (line 3 minus line 4)	33,182	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANTS, PURCH DISC, RENT INCOME	1,645,012	24.00
25.00	Total other income (sum of lines 6-24)	1,645,012	25.00
26.00	Total (line 5 plus line 25)	1,678,194	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,678,194	29.00