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: 151330	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/26/2016 2:26 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/26/2016 Time: 2:26 pm
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 ADAMS MEMORIAL HOSPITAL (151330) 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.

Encryption Information

ECR: Date: 5/26/2016 Time: 2:26 pm
sYZQQr9c6QWLuuWBhDTwL3mORkzE60
tkyfm0Ng1JqLIfn:m:BkT2QNsI:Cz3
wmGr0tWray01Jm8w

PI: Date: 5/26/2016 Time: 2:26 pm
GQ5WMulgEg97aaopYPpvfoP1QKIfZ0
1MOqk0Gavi0NuRKu.O.4H5xxaexvfe
jjtj0SQT5U0Jdjij

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

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital	0	612,005	176,302	0	0	1.00
2.00	Subprovider - IPF	0	1	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	612,006	176,302	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2016 2:24 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1100 MERCER AVENEUE	PO Box:			1.00
2.00	City: DECATUR	State: IN	Zip Code: 46733	County: ADAMS	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	ADAMS MEMORIAL HOSPITAL	151330	99915	1	11/01/2005	N	O	P	3.00
4.00	Subprovider - IPF	ADAMS MEMORIAL HOSPITAL	15M330	99915	4	11/01/2005	N	P	P	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ADAMS MEMORIAL HOSPITAL	15Z330	99915		11/01/2005	N	O	P	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2015	12/31/2015	20.00
21.00	Type of Control (see instructions)	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.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 2:24 pm

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

		V	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)				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: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 2:24 pm

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

	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: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 2:24 pm

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

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

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

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	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.	N		108.00

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	121,823	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151330	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 2:24 pm

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H060	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: ADAMS HEALTH NETWORK	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1100 MERCER AVE	PO Box:		142.00
143.00	City: DECATUR	State: IN	Zip Code: 46733	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	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)	10/01/2015	09/30/2016	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151330	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 2:24 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2016 2:24 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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	05/12/2016	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: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2016 2:24 pm

		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.				Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		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.	SKANDER	NASSER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BRADLEY ASSOCIATES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-237-5500	SKANDERN@BRADLEYCPA.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2016 2:24 pm

		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)	05/12/2016			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.		PARTNER		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: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2016 2:24 pm

	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	21	7,665	104,592.00	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)		21	7,665	104,592.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	17,520.00	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	122,112.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			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)		35				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: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2016 2:24 pm

	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)	2,019	168	4,285			1.00
2.00	HMO and other (see instructions)	593	0				2.00
3.00	HMO IPF Subprovider	31	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	125			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,019	168	4,410			7.00
8.00	INTENSIVE CARE UNIT	348	15	730			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		30	409			13.00
14.00	Total (see instructions)	2,367	213	5,549	0.00	350.04	14.00
15.00	CAH visits	31,967	6,886	113,859			15.00
16.00	SUBPROVIDER - IPF	332	162	1,765	0.00	19.84	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	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	369.88	27.00
28.00	Observation Bed Days		0	915			28.00
29.00	Ambulance Trips	811					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	73			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: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2016 2:24 pm

	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	559	78	1,590	1.00
2.00	HMO and other (see instructions)			144	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	559	78	1,590	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	49	43	400	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					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: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-10 | Date/Time Prepared: 5/26/2016 2:24 pm

		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)	0.422699	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,402,591	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	8,616,771	6.00
7.00	Medicaid cost (line 1 times line 6)	3,642,300	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)	2,239,709	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	100,000	9.00
10.00	Stand-alone SCHIP charges	200,000	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	84,540	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)	2,239,709	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	2,137,292	0	2,137,292	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	903,431	0	903,431	21.00
22.00	Partial payment by patients approved for charity care	33,236	0	33,236	22.00
23.00	Cost of charity care (line 21 minus line 22)	870,195	0	870,195	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,133,501	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	397,340	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,736,161	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,579,272	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,449,467	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,689,176	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/26/2016 2:24 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,545,342	2,545,342	56,222	2,601,564	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
2.01	00201	OTHER CAP		285	285	0	285	2.01
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,640,859	5,640,859	0	5,640,859	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,316,152	7,033,866	8,350,018	-50,462	8,299,556	5.00
7.00	00700	OPERATION OF PLANT	350,417	706,641	1,057,058	0	1,057,058	7.00
7.01	00701	BIO-MEDICAL	95,471	40,767	136,238	0	136,238	7.01
7.02	00702	UTILITIES - HOSPITAL	0	830,432	830,432	7,403	837,835	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	134,274	134,274	-7,403	126,871	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	47,517	127,888	175,405	0	175,405	8.00
9.00	00900	HOUSEKEEPING	427,689	79,965	507,654	0	507,654	9.00
10.00	01000	DIETARY	640,908	678,682	1,319,590	-969,166	350,424	10.00
11.00	01100	CAFETERIA	0	0	0	969,166	969,166	11.00
13.00	01300	NURSING ADMINISTRATION	863,239	44,072	907,311	0	907,311	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	655,600	188,004	843,604	0	843,604	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	422,309	217,878	640,187	0	640,187	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,092,054	238,027	2,330,081	359,330	2,689,411	30.00
31.00	03100	INTENSIVE CARE UNIT	594,968	29,987	624,955	0	624,955	31.00
40.00	04000	SUBPROVIDER - IPF	1,072,158	153,023	1,225,181	-260,745	964,436	40.00
43.00	04300	NURSERY	0	0	0	189,491	189,491	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,119,305	777,843	2,897,148	0	2,897,148	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	651,074	53,165	704,239	-548,821	155,418	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	957,150	840,606	1,797,756	0	1,797,756	54.00
60.00	06000	LABORATORY	1,016,367	1,750,170	2,766,537	0	2,766,537	60.00
65.00	06500	RESPIRATORY THERAPY	620,163	156,255	776,418	0	776,418	65.00
66.00	06600	PHYSICAL THERAPY	708,025	44,294	752,319	0	752,319	66.00
67.00	06700	OCCUPATIONAL THERAPY	228,910	18,231	247,141	0	247,141	67.00
68.00	06800	SPEECH PATHOLOGY	126,718	11,929	138,647	0	138,647	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,168,926	1,168,926	0	1,168,926	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	786,555	786,555	0	786,555	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,861,489	1,861,489	0	1,861,489	73.00
76.00	03020	OP PSYCH	0	0	0	274,401	274,401	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	920,973	121,189	1,042,162	0	1,042,162	90.00
90.01	09001	CLINIC - AMO	1,091,134	39,340	1,130,474	0	1,130,474	90.01
90.02	09002	CLINIC - AMH NEURO	89,479	9,707	99,186	0	99,186	90.02
90.03	09003	CLINIC - NIGLIAZZO	1,155,606	129,712	1,285,318	0	1,285,318	90.03
91.00	09100	EMERGENCY	2,221,565	161,720	2,383,285	0	2,383,285	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,037,118	182,634	1,219,752	0	1,219,752	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,522,069	26,803,757	48,325,826	19,416	48,345,242	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	771,128	149,068	920,196	0	920,196	194.01
194.02	07952	OTHER MOBS	438,621	430,864	869,485	-19,416	850,069	194.02
194.03	07953	MONROE	561,651	127,804	689,455	0	689,455	194.03
200.00		TOTAL (SUM OF LINES 118-199)	23,293,469	27,511,493	50,804,962	0	50,804,962	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/26/2016 2:24 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-153,557	2,448,007		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
2.01	00201	OTHER CAP	0	285		2.01
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,640,859		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-194,008	8,105,548		5.00
7.00	00700	OPERATION OF PLANT	0	1,057,058		7.00
7.01	00701	BIO-MEDICAL	0	136,238		7.01
7.02	00702	UTILITIES - HOSPITAL	0	837,835		7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	126,871		7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	175,405		8.00
9.00	00900	HOUSEKEEPING	0	507,654		9.00
10.00	01000	DIETARY	0	350,424		10.00
11.00	01100	CAFETERIA	-425,883	543,283		11.00
13.00	01300	NURSING ADMINISTRATION	-49,869	857,442		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	0	843,604		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-27,454	612,733		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-820,825	1,868,586		30.00
31.00	03100	INTENSIVE CARE UNIT	-853	624,102		31.00
40.00	04000	SUBPROVIDER - IPF	-204,982	759,454		40.00
43.00	04300	NURSERY	0	189,491		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,369,625	1,527,523		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	155,418		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,797,756		54.00
60.00	06000	LABORATORY	-58,740	2,707,797		60.00
65.00	06500	RESPIRATORY THERAPY	-85,992	690,426		65.00
66.00	06600	PHYSICAL THERAPY	0	752,319		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	247,141		67.00
68.00	06800	SPEECH PATHOLOGY	0	138,647		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,168,926		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	786,555		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-160,135	1,701,354		73.00
76.00	03020	OP PSYCH	0	274,401		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-596,594	445,568		90.00
90.01	09001	CLINIC - AMO	-685,401	445,073		90.01
90.02	09002	CLINIC - AMH NEURO	0	99,186		90.02
90.03	09003	CLINIC - NIGLIAZZO	-930,747	354,571		90.03
91.00	09100	EMERGENCY	-1,196,530	1,186,755		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-45	1,219,707		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,961,240	41,384,002		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	TITLE XX	0	0		194.00
194.01	07951	OTHER NRCC	0	920,196		194.01
194.02	07952	OTHER MOBS	0	850,069		194.02
194.03	07953	MONROE	0	689,455		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-6,961,240	43,843,722		200.00

RECLASSIFICATIONS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/26/2016 2:24 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - OB, NURSERY AND L&D				
1.00	ADULTS & PEDIATRICS	30.00	332,203	27,127	1.00
2.00	NURSERY	43.00	175,186	14,305	2.00
	TOTALS		507,389	41,432	
	B - INSURANCE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	56,222	1.00
	TOTALS		0	56,222	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	470,712	498,454	1.00
	TOTALS		470,712	498,454	
	D - O/P PSYCH				
1.00	OP PSYCH	76.00	228,178	32,567	1.00
	TOTALS		228,178	32,567	
	E - HOSPITAL USE OF SWISS CITY				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,760	1.00
2.00	OP PSYCH	76.00	0	13,656	2.00
3.00	UTILITIES - HOSPITAL	7.02	0	7,403	3.00
	TOTALS		0	26,819	
500.00	Grand Total: Increases		1,206,279	655,494	500.00

RECLASSIFICATIONS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/26/2016 2:24 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - OB, NURSERY AND L&D					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	507,389	41,432	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		507,389	41,432		
	B - INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	56,222	12	1.00
	TOTALS		0	56,222		
	C - CAFETERIA					
1.00	DIETARY	10.00	470,712	498,454	0	1.00
	TOTALS		470,712	498,454		
	D - O/P PSYCH					
1.00	SUBPROVIDER - IPF	40.00	228,178	32,567	0	1.00
	TOTALS		228,178	32,567		
	E - HOSPITAL USE OF SWISS CITY					
1.00	OTHER MOBS	194.02	0	19,416	0	1.00
2.00	UTILITIES - OFFSITE BLDGS	7.03	0	7,403	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	26,819		
500.00	Grand Total: Decreases		1,206,279	655,494		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2016 2:24 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	359,555	7,689	0	7,689	0	1.00
2.00	Land Improvements	1,558,293	66,387	0	66,387	0	2.00
3.00	Buildings and Fixtures	38,118,082	199,748	0	199,748	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,394,016	197,684	0	197,684	0	5.00
6.00	Movable Equipment	21,555,348	1,891,894	0	1,891,894	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,985,294	2,363,402	0	2,363,402	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	65,985,294	2,363,402	0	2,363,402	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	367,244	0	1.00
2.00	Land Improvements	1,624,680	0	2.00
3.00	Buildings and Fixtures	38,317,830	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,591,700	0	5.00
6.00	Movable Equipment	23,447,242	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	68,348,696	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	68,348,696	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/26/2016 2:24 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,351,904	0	1,193,438	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
2.01	OTHER CAP	0	285	0	0	0	2.01
3.00	Total (sum of lines 1-2)	1,351,904	285	1,193,438	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,545,342	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
2.01	OTHER CAP	0	285	2.01
3.00	Total (sum of lines 1-2)	0	2,545,627	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2016 2:24 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	63,348,695	0	63,348,695	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
2.01	OTHER CAP	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	63,348,695	0	63,348,695	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,351,904	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
2.01	OTHER CAP	0	0	0	0	285	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1,351,904	285	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,039,881	56,222	0	0	2,448,007	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
2.01	OTHER CAP	0	0	0	0	285	2.01
3.00	Total (sum of lines 1-2)	1,039,881	56,222	0	0	2,448,292	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/26/2016 2:24 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-139,494	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - OTHER CAP (chapter 2)		0	OTHER CAP	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-7,445	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,807,013			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	-218,396			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-425,883	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	B	-160,135	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-27,454	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - OTHER CAP		0	OTHER CAP	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/26/2016 2:24 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	IHA DUES	A	-757	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	AHA DUES	A	-3,324	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	TRANSPORATION REVENUE	B	-45	AMBULANCE SERVICES	95.00	0	33.02
33.03	JAY COUNTY MGMT REVENUE	B	-99,962	SUBPROVIDER - IPF	40.00	0	33.03
33.04	WORTHMAN FITNESS CENTER	B	-85,992	RESPIRATORY THERAPY	65.00	0	33.04
33.05	MISC INCOME	B	-134,111	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ECU RUN-OFF EXPENSES	A	-853	INTENSIVE CARE UNIT	31.00	0	33.06
33.07	HOSPITAL PROVIDER TAX SHORTFALL	A	477,206	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08			0		0.00	0	33.08
33.09	MARKETING	A	-321,233	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10			0		0.00	0	33.10
33.11	HOSPITALIST IT EXPENSE	A	-11	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	HOSPITALIST OTHER	A	-6,338	ADULTS & PEDIATRICS	30.00	0	33.12
33.13			0		0.00	0	33.13
33.14			0		0.00	0	33.14
33.15			0		0.00	0	33.15
33.16			0		0.00	0	33.16
33.17			0		0.00	0	33.17
33.18			0		0.00	0	33.18
33.19			0		0.00	0	33.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,961,240				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2016 2:24 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	AHN - INTEREST	0	14,063	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	AHN- A&G	2,550,919	2,755,252	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	0		0	2,550,919	2,769,315	5.00

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

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

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

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

6.00	B		0.00	ADAMS HEALTH NETWORK	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 151330	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-1 Date/Time Prepared: 5/26/2016 2:24 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-14,063	11		1.00
2.00	-204,333	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-218,396			5.00

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

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

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

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

6.00	MANAGEMENT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2016 2:24 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	13.00	NURSING ADMINISTRATION	39,895	39,895	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	754,302	754,302	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	105,020	105,020	0	0	0	3.00
4.00	50.00	OPERATING ROOM	1,140,843	1,140,843	0	0	0	4.00
5.00	60.00	LABORATORY	60,000	58,740	1,260	0	0	5.00
6.00	90.00	CLINIC	515,251	515,251	0	0	0	6.00
7.00	90.01	CLINIC - AMO	651,333	651,333	0	0	0	7.00
8.00	90.03	CLINIC - NIGLIAZZO	868,900	868,900	0	0	0	8.00
9.00	91.00	EMERGENCY	1,527,583	1,099,355	428,228	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	13.00	NURSING ADMINISTRATION	9,974	9,974	0	0	0	11.00
12.00	30.00	ADULTS & PEDIATRICS	60,185	60,185	0	0	0	12.00
13.00	50.00	OPERATING ROOM	228,782	228,782	0	0	0	13.00
14.00	90.00	CLINIC	81,343	81,343	0	0	0	14.00
15.00	90.01	CLINIC - AMO	34,068	34,068	0	0	0	15.00
16.00	90.03	CLINIC - NIGLIAZZO	61,847	61,847	0	0	0	16.00
17.00	91.00	EMERGENCY	97,175	97,175	0	0	0	17.00
200.00			6,236,501	5,807,013	429,488		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	13.00	NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.01	CLINIC - AMO	0	0	0	0	0	7.00
8.00	90.03	CLINIC - NIGLIAZZO	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	11.00
12.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	12.00
13.00	50.00	OPERATING ROOM	0	0	0	0	0	13.00
14.00	90.00	CLINIC	0	0	0	0	0	14.00
15.00	90.01	CLINIC - AMO	0	0	0	0	0	15.00
16.00	90.03	CLINIC - NIGLIAZZO	0	0	0	0	0	16.00
17.00	91.00	EMERGENCY	0	0	0	0	0	17.00
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	13.00	NURSING ADMINISTRATION	0	0	0	39,895		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	754,302		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	105,020		3.00
4.00	50.00	OPERATING ROOM	0	0	0	1,140,843		4.00
5.00	60.00	LABORATORY	0	0	0	58,740		5.00
6.00	90.00	CLINIC	0	0	0	515,251		6.00
7.00	90.01	CLINIC - AMO	0	0	0	651,333		7.00
8.00	90.03	CLINIC - NIGLIAZZO	0	0	0	868,900		8.00
9.00	91.00	EMERGENCY	0	0	0	1,099,355		9.00
10.00	0.00		0	0	0	0		10.00
11.00	13.00	NURSING ADMINISTRATION	0	0	0	9,974		11.00
12.00	30.00	ADULTS & PEDIATRICS	0	0	0	60,185		12.00
13.00	50.00	OPERATING ROOM	0	0	0	228,782		13.00
14.00	90.00	CLINIC	0	0	0	81,343		14.00
15.00	90.01	CLINIC - AMO	0	0	0	34,068		15.00
16.00	90.03	CLINIC - NIGLIAZZO	0	0	0	61,847		16.00
17.00	91.00	EMERGENCY	0	0	0	97,175		17.00
200.00			0	0	0	5,807,013		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/26/2016 2:24 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				NEW BLDG & FIXT	NEW MVBLE EQUIP	OTHER CAP		
			0	1.00	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,448,007	2,448,007				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0		0			2.00
2.01	00201	OTHER CAP	285		0	285		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,640,859	0	0	0	5,640,859	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,105,548	302,764	0	44	318,726	5.00
7.00	00700	OPERATION OF PLANT	1,057,058	370,413	0	35	84,859	7.00
7.01	00701	BIO-MEDICAL	136,238	8,976	0	1	23,120	7.01
7.02	00702	UTILITIES - HOSPITAL	837,835	0	0	0	0	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	126,871	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	175,405	35,594	0	3	11,507	8.00
9.00	00900	HOUSEKEEPING	507,654	48,460	0	5	103,571	9.00
10.00	01000	DIETARY	350,424	14,410	0	1	41,216	10.00
11.00	01100	CAFETERIA	543,283	128,747	0	12	113,990	11.00
13.00	01300	NURSING ADMINISTRATION	857,442	12,084	0	1	209,046	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	843,604	32,629	0	3	158,763	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	612,733	52,269	0	5	102,268	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,868,586	346,324	0	32	587,068	30.00
31.00	03100	INTENSIVE CARE UNIT	624,102	66,370	0	6	144,080	31.00
40.00	04000	SUBPROVIDER - IPF	759,454	147,172	0	14	204,382	40.00
43.00	04300	NURSERY	189,491	34,894	0	3	42,424	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,527,523	225,729	0	21	513,221	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	155,418	24,395	0	2	34,795	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,797,756	182,292	0	17	231,788	54.00
60.00	06000	LABORATORY	2,707,797	66,123	0	8	246,129	60.00
65.00	06500	RESPIRATORY THERAPY	690,426	84,178	0	8	150,182	65.00
66.00	06600	PHYSICAL THERAPY	752,319	71,538	0	7	171,459	66.00
67.00	06700	OCCUPATIONAL THERAPY	247,141	2,059	0	0	55,434	67.00
68.00	06800	SPEECH PATHOLOGY	138,647	1,029	0	0	30,687	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,168,926	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	786,555	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,701,354	0	0	0	0	73.00
76.00	03020	OP PSYCH	274,401	0	0	1	55,257	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	445,568	0	0	8	223,027	90.00
90.01	09001	CLINIC - AMO	445,073	0	0	4	264,234	90.01
90.02	09002	CLINIC - AMH NEURO	99,186	0	0	0	21,669	90.02
90.03	09003	CLINIC - NIGLIAZZO	354,571	0	0	4	279,847	90.03
91.00	09100	EMERGENCY	1,186,755	111,310	0	10	537,985	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,219,707	0	0	8	251,154	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,384,002	2,369,759	0	263	5,211,888	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,463	0	1	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	920,196	64,785	0	13	186,740	194.01
194.02	07952	OTHER MOBS	850,069	0	0	5	106,219	194.02
194.03	07953	MONROE	689,455	0	0	3	136,012	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	43,843,722	2,448,007	0	285	5,640,859	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/26/2016 2:24 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	BIO-MEDICAL	UTILITIES - HOSPITAL	
			4A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,727,082	8,727,082				5.00
7.00	00700	OPERATION OF PLANT	1,512,365	375,848	1,888,213			7.00
7.01	00701	BIO-MEDICAL	168,335	41,834	7,550	217,719		7.01
7.02	00702	UTILITIES - HOSPITAL	837,835	208,216	0	0	1,046,051	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	126,871	31,530	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	222,509	55,297	29,942	0	21,085	8.00
9.00	00900	HOUSEKEEPING	659,690	163,944	47,675	0	28,707	9.00
10.00	01000	DIETARY	406,051	100,911	12,122	0	8,536	10.00
11.00	01100	CAFETERIA	786,032	195,342	108,305	0	76,267	11.00
13.00	01300	NURSING ADMINISTRATION	1,078,573	268,044	10,165	0	7,158	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,034,999	257,215	27,448	0	19,329	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	767,275	190,681	43,970	0	30,963	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,802,010	696,347	291,337	33,715	205,154	30.00
31.00	03100	INTENSIVE CARE UNIT	834,558	207,402	55,832	1,152	39,316	31.00
40.00	04000	SUBPROVIDER - IPF	1,111,022	276,108	123,804	62	87,181	40.00
43.00	04300	NURSERY	266,812	66,307	29,353	2,310	20,670	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,266,494	563,262	189,888	51,003	133,717	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	214,610	53,334	20,521	1,765	14,451	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,211,853	549,683	153,348	96,185	107,986	54.00
60.00	06000	LABORATORY	3,020,057	750,536	67,989	9,693	39,170	60.00
65.00	06500	RESPIRATORY THERAPY	924,794	229,827	70,812	9,493	49,865	65.00
66.00	06600	PHYSICAL THERAPY	995,323	247,355	60,179	3,779	42,377	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,634	75,707	1,732	0	1,219	67.00
68.00	06800	SPEECH PATHOLOGY	170,363	42,338	866	0	610	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,168,926	290,498	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	786,555	195,472	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,701,354	422,815	0	0	0	73.00
76.00	03020	OP PSYCH	329,659	81,926	6,927	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	668,603	166,159	75,955	81	0	90.00
90.01	09001	CLINIC - AMO	709,311	176,276	33,856	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	120,855	30,035	0	352	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	634,422	157,665	40,264	714	0	90.03
91.00	09100	EMERGENCY	1,836,060	456,292	93,637	1,551	65,938	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,470,869	365,536	74,864	5,442	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	40,876,761	7,989,742	1,678,341	217,297	999,699	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,464	3,346	11,326	0	7,975	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	1,171,734	291,196	120,375	422	38,377	194.01
194.02	07952	OTHER MOBS	956,293	237,655	48,489	0	0	194.02
194.03	07953	MONROE	825,470	205,143	29,682	0	0	194.03
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	43,843,722	8,727,082	1,888,213	217,719	1,046,051	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/26/2016 2:24 pm

		Cost Center Description	UTILITIES - OFFSITE BLDGS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.03	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	BIO-MEDICAL						7.01
7.02	00702	UTILITIES - HOSPITAL						7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	158,401					7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	328,833				8.00
9.00	00900	HOUSEKEEPING	0	51,081	951,097			9.00
10.00	01000	DIETARY	0	3,896	6,394	537,910		10.00
11.00	01100	CAFETERIA	0	10,776	57,130	0	1,233,852	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	5,362	0	54,941	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	14,479	0	33,887	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	23,194	0	45,566	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	32,446	153,679	345,579	165,227	30.00
31.00	03100	INTENSIVE CARE UNIT	0	11,911	29,451	56,273	47,934	31.00
40.00	04000	SUBPROVIDER - IPF	0	8,029	65,306	136,058	72,095	40.00
43.00	04300	NURSERY	0	17,675	15,484	0	12,267	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	54,553	100,165	0	88,401	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	15,568	10,825	0	10,063	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,424	80,890	0	78,611	54.00
60.00	06000	LABORATORY	0	179	35,864	0	102,073	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,620	37,353	0	56,221	65.00
66.00	06600	PHYSICAL THERAPY	0	16,758	31,744	0	73,467	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	913	0	34,866	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	457	0	9,668	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 PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	2,171	3,654	0	19,491	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,940	40,066	0	45,650	90.00
90.01	09001	CLINIC - AMO	5,883	45	17,859	0	30,254	90.01
90.02	09002	CLINIC - AMH NEURO	0	8	0	0	4,208	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	1,327	21,239	0	30,984	90.03
91.00	09100	EMERGENCY	0	44,964	49,393	0	58,106	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	12,287	13,568	39,490	0	114,278	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,170	326,939	840,391	537,910	1,188,258	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	5,974	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	17,784	1,091	63,497	0	45,594	194.01
194.02	07952	OTHER MOBS	113,024	114	25,578	0	0	194.02
194.03	07953	MONROE	9,423	689	15,657	0	0	194.03
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)	158,401	328,833	951,097	537,910	1,233,852	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/26/2016 2:24 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	BIO-MEDICAL						7.01
7.02	00702	UTILITIES - HOSPITAL						7.02
7.03	00703	UTILITIES - OFFSITE BLDGS						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,424,243					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500	PHARMACY	0	0	1,387,357			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,101,649		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	518,231	0	0	353,964	5,597,689	30.00
31.00	03100	INTENSIVE CARE UNIT	150,342	0	0	29,979	1,464,150	31.00
40.00	04000	SUBPROVIDER - IPF	226,122	0	0	79,441	2,185,228	40.00
43.00	04300	NURSERY	38,475	0	0	1,538	470,891	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	277,266	0	0	101,120	3,825,869	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,562	0	0	1,261	373,960	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,616	3,322,596	54.00
60.00	06000	LABORATORY	0	0	0	0	4,025,561	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,475	1,396,460	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	1,470,982	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	419,071	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	224,302	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	1,459,424	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	982,027	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,387,357	0	3,511,526	73.00
76.00	03020	OP PSYCH	0	0	0	21,478	465,306	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,187	1,003,641	90.00
90.01	09001	CLINIC - AMO	0	0	0	8,975	982,459	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	452	155,910	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	6,329	892,944	90.03
91.00	09100	EMERGENCY	182,245	0	0	455,040	3,243,226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	2,096,334	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,424,243	0	1,387,357	1,086,855	39,569,556	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	42,085	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	9,836	1,759,906	194.01
194.02	07952	OTHER MOBS	0	0	0	3,002	1,384,155	194.02
194.03	07953	MONROE	0	0	0	1,956	1,088,020	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,424,243	0	1,387,357	1,101,649	43,843,722	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/26/2016 2:24 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	OTHER CAP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	BIO-MEDICAL				7.01
7.02	00702	UTILITIES - HOSPITAL				7.02
7.03	00703	UTILITIES - OFFSITE BLDGS				7.03
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	5,597,689		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,464,150		31.00
40.00	04000	SUBPROVIDER - IPF	0	2,185,228		40.00
43.00	04300	NURSERY	0	470,891		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,825,869		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	373,960		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,322,596		54.00
60.00	06000	LABORATORY	0	4,025,561		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,396,460		65.00
66.00	06600	PHYSICAL THERAPY	0	1,470,982		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	419,071		67.00
68.00	06800	SPEECH PATHOLOGY	0	224,302		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,459,424		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	982,027		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,511,526		73.00
76.00	03020	OP PSYCH	0	465,306		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	1,003,641		90.00
90.01	09001	CLINIC - AMO	0	982,459		90.01
90.02	09002	CLINIC - AMH NEURO	0	155,910		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	892,944		90.03
91.00	09100	EMERGENCY	0	3,243,226		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	2,096,334		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	39,569,556		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	42,085		190.00
194.00	07950	TITLE XX	0	0		194.00
194.01	07951	OTHER NRCC	0	1,759,906		194.01
194.02	07952	OTHER MOBS	0	1,384,155		194.02
194.03	07953	MONROE	0	1,088,020		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	43,843,722		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/26/2016 2:24 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP	OTHER CAP		
			0	1.00	2.00	2.01	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	161,729	302,764	0	44	464,537	5.00
7.00	00700	OPERATION OF PLANT	157,175	370,413	0	35	527,623	7.00
7.01	00701	BIO-MEDICAL	1,703	8,976	0	1	10,680	7.01
7.02	00702	UTILITIES - HOSPITAL	0	0	0	0	0	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	33,135	35,594	0	3	68,732	8.00
9.00	00900	HOUSEKEEPING	3,026	48,460	0	5	51,491	9.00
10.00	01000	DIETARY	40,753	14,410	0	1	55,164	10.00
11.00	01100	CAFETERIA	0	128,747	0	12	128,759	11.00
13.00	01300	NURSING ADMINISTRATION	90	12,084	0	1	12,175	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	2,089	32,629	0	3	34,721	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	343	52,269	0	5	52,617	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	121,660	346,324	0	32	468,016	30.00
31.00	03100	INTENSIVE CARE UNIT	9,068	66,370	0	6	75,444	31.00
40.00	04000	SUBPROVIDER - IPF	3,102	147,172	0	14	150,288	40.00
43.00	04300	NURSERY	0	34,894	0	3	34,897	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	274,397	225,729	0	21	500,147	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,651	24,395	0	2	37,048	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	182,292	0	17	182,309	54.00
60.00	06000	LABORATORY	66,847	66,123	0	8	132,978	60.00
65.00	06500	RESPIRATORY THERAPY	40,486	84,178	0	8	124,672	65.00
66.00	06600	PHYSICAL THERAPY	1,041	71,538	0	7	72,586	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,059	0	0	2,059	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,029	0	0	1,029	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 PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	1	1	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,702	0	0	8	3,710	90.00
90.01	09001	CLINIC - AMO	0	0	0	4	4	90.01
90.02	09002	CLINIC - AMH NEURO	3,468	0	0	0	3,468	90.02
90.03	09003	CLINIC - NIGLIAZZO	8,502	0	0	4	8,506	90.03
91.00	09100	EMERGENCY	11,513	111,310	0	10	122,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	119,912	0	0	8	119,920	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,076,392	2,369,759	0	263	3,446,414	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,463	0	1	13,464	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	90,313	64,785	0	13	155,111	194.01
194.02	07952	OTHER MOBS	179,275	0	0	5	179,280	194.02
194.03	07953	MONROE	33,961	0	0	3	33,964	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,379,941	2,448,007	0	285	3,828,233	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/26/2016 2:24 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	BIO-MEDICAL	UTILITIES - HOSPITAL	
			4.00	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	464,537				5.00
7.00	00700	OPERATION OF PLANT	0	20,006	547,629			7.00
7.01	00701	BIO-MEDICAL	0	2,227	2,190	15,097		7.01
7.02	00702	UTILITIES - HOSPITAL	0	11,083	0	0	11,083	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	1,678	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,943	8,684	0	223	8.00
9.00	00900	HOUSEKEEPING	0	8,726	13,827	0	304	9.00
10.00	01000	DIETARY	0	5,371	3,516	0	90	10.00
11.00	01100	CAFETERIA	0	10,398	31,411	0	808	11.00
13.00	01300	NURSING ADMINISTRATION	0	14,267	2,948	0	76	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	13,691	7,961	0	205	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,150	12,752	0	328	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	37,065	84,495	2,337	2,173	30.00
31.00	03100	INTENSIVE CARE UNIT	0	11,040	16,193	80	417	31.00
40.00	04000	SUBPROVIDER - IPF	0	14,697	35,906	4	924	40.00
43.00	04300	NURSERY	0	3,529	8,513	160	219	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	29,981	55,072	3,535	1,417	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,839	5,952	122	153	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29,258	44,475	6,674	1,144	54.00
60.00	06000	LABORATORY	0	39,961	19,719	672	415	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,233	20,537	658	528	65.00
66.00	06600	PHYSICAL THERAPY	0	13,166	17,453	262	449	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,030	502	0	13	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,254	251	0	6	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,463	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	10,405	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,506	0	0	0	73.00
76.00	03020	OP PSYCH	0	4,361	2,009	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	8,844	22,029	6	0	90.00
90.01	09001	CLINIC - AMO	0	9,383	9,819	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	1,599	0	24	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	8,392	11,677	49	0	90.03
91.00	09100	EMERGENCY	0	24,287	27,157	108	699	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	19,457	21,712	377	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	425,290	486,760	15,068	10,591	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	178	3,285	0	85	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	15,500	34,912	29	407	194.01
194.02	07952	OTHER MOBS	0	12,650	14,063	0	0	194.02
194.03	07953	MONROE	0	10,919	8,609	0	0	194.03
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)	0	464,537	547,629	15,097	11,083	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/26/2016 2:24 pm

		Cost Center Description	UTILITIES - OFFSITE BLDGS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.03	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	BIO-MEDICAL						7.01
7.02	00702	UTILITIES - HOSPITAL						7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	1,678					7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	80,582				8.00
9.00	00900	HOUSEKEEPING	0	12,518	86,866			9.00
10.00	01000	DIETARY	0	955	584	65,680		10.00
11.00	01100	CAFETERIA	0	2,641	5,218	0	179,235	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	490	0	7,981	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	1,322	0	4,923	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	2,118	0	6,619	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,951	14,035	42,196	24,001	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,919	2,690	6,871	6,963	31.00
40.00	04000	SUBPROVIDER - IPF	0	1,968	5,965	16,613	10,473	40.00
43.00	04300	NURSERY	0	4,331	1,414	0	1,782	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,368	9,148	0	12,842	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,815	989	0	1,462	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,700	7,388	0	11,419	54.00
60.00	06000	LABORATORY	0	44	3,276	0	14,828	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,112	3,412	0	8,167	65.00
66.00	06600	PHYSICAL THERAPY	0	4,107	2,899	0	10,672	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	83	0	5,065	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	42	0	1,404	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 PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	532	334	0	2,831	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	475	3,659	0	6,631	90.00
90.01	09001	CLINIC - AMO	62	11	1,631	0	4,395	90.01
90.02	09002	CLINIC - AMH NEURO	0	2	0	0	611	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	325	1,940	0	4,501	90.03
91.00	09100	EMERGENCY	0	11,019	4,511	0	8,441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	130	3,325	3,607	0	16,601	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	192	80,118	76,755	65,680	172,612	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	546	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	188	267	5,799	0	6,623	194.01
194.02	07952	OTHER MOBS	1,198	28	2,336	0	0	194.02
194.03	07953	MONROE	100	169	1,430	0	0	194.03
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)	1,678	80,582	86,866	65,680	179,235	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/26/2016 2:24 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	BIO-MEDICAL						7.01
7.02	00702	UTILITIES - HOSPITAL						7.02
7.03	00703	UTILITIES - OFFSITE BLDGS						7.03
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	37,937					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500	PHARMACY	0	0	62,823			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	84,584		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,804	0	0	27,177	723,250	30.00
31.00	03100	INTENSIVE CARE UNIT	4,005	0	0	2,302	128,924	31.00
40.00	04000	SUBPROVIDER - IPF	6,023	0	0	6,099	248,960	40.00
43.00	04300	NURSERY	1,025	0	0	118	55,988	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,385	0	0	7,764	640,659	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	841	0	0	97	53,318	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	969	291,336	54.00
60.00	06000	LABORATORY	0	0	0	0	211,893	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	727	173,046	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	121,594	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	11,752	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	4,986	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	15,463	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	10,405	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	62,823	0	85,329	73.00
76.00	03020	OP PSYCH	0	0	0	1,649	11,717	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	398	45,752	90.00
90.01	09001	CLINIC - AMO	0	0	0	689	25,994	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	35	5,739	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	486	35,876	90.03
91.00	09100	EMERGENCY	4,854	0	0	34,938	238,847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	185,129	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	37,937	0	62,823	83,448	3,325,957	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	17,558	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	755	219,591	194.01
194.02	07952	OTHER MOBS	0	0	0	231	209,786	194.02
194.03	07953	MONROE	0	0	0	150	55,341	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	37,937	0	62,823	84,584	3,828,233	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/26/2016 2:24 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	OTHER CAP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	BIO-MEDICAL				7.01
7.02	00702	UTILITIES - HOSPITAL				7.02
7.03	00703	UTILITIES - OFFSITE BLDGS				7.03
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	723,250		30.00
31.00	03100	INTENSIVE CARE UNIT	0	128,924		31.00
40.00	04000	SUBPROVIDER - IPF	0	248,960		40.00
43.00	04300	NURSERY	0	55,988		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	640,659		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	53,318		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	291,336		54.00
60.00	06000	LABORATORY	0	211,893		60.00
65.00	06500	RESPIRATORY THERAPY	0	173,046		65.00
66.00	06600	PHYSICAL THERAPY	0	121,594		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,752		67.00
68.00	06800	SPEECH PATHOLOGY	0	4,986		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,463		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	10,405		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	85,329		73.00
76.00	03020	OP PSYCH	0	11,717		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	45,752		90.00
90.01	09001	CLINIC - AMO	0	25,994		90.01
90.02	09002	CLINIC - AMH NEURO	0	5,739		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	35,876		90.03
91.00	09100	EMERGENCY	0	238,847		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	185,129		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,325,957		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,558		190.00
194.00	07950	TITLE XX	0	0		194.00
194.01	07951	OTHER NRCC	0	219,591		194.01
194.02	07952	OTHER MOBS	0	209,786		194.02
194.03	07953	MONROE	0	55,341		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	3,828,233		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 2:24 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OTHER CAP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	2.00	2.01	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	118,914					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0				2.00
2.01	00201	OTHER CAP		0	147,671			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	23,293,469		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,707	0	20,374	1,316,152	-8,727,082	5.00
7.00	00700	OPERATION OF PLANT	17,993	0	18,263	350,417	0	7.00
7.01	00701	BIO-MEDICAL	436	0	436	95,471	0	7.01
7.02	00702	UTILITIES - HOSPITAL	0	0	0	0	0	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	1,729	0	1,729	47,517	0	8.00
9.00	00900	HOUSEKEEPING	2,354	0	2,753	427,689	0	9.00
10.00	01000	DIETARY	700	0	700	170,196	0	10.00
11.00	01100	CAFETERIA	6,254	0	6,254	470,712	0	11.00
13.00	01300	NURSING ADMINISTRATION	587	0	587	863,239	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,585	0	1,585	655,600	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,539	0	2,539	422,309	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,823	0	16,823	2,424,257	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,224	0	3,224	594,968	0	31.00
40.00	04000	SUBPROVIDER - IPF	7,149	0	7,149	843,980	0	40.00
43.00	04300	NURSERY	1,695	0	1,695	175,186	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,965	0	10,965	2,119,305	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,185	0	1,185	143,685	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,855	0	8,855	957,150	0	54.00
60.00	06000	LABORATORY	3,212	0	3,926	1,016,367	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,089	0	4,089	620,163	0	65.00
66.00	06600	PHYSICAL THERAPY	3,475	0	3,475	708,025	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	100	0	100	228,910	0	67.00
68.00	06800	SPEECH PATHOLOGY	50	0	50	126,718	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 PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	400	228,178	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	4,386	920,973	0	90.00
90.01	09001	CLINIC - AMO	0	0	1,955	1,091,134	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	89,479	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	2,325	1,155,606	0	90.03
91.00	09100	EMERGENCY	5,407	0	5,407	2,221,565	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	4,323	1,037,118	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	115,113	0	135,552	21,522,069	-8,727,082	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	654	0	654	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	3,147	0	6,951	771,128	0	194.01
194.02	07952	OTHER MOBS	0	0	2,800	438,621	0	194.02
194.03	07953	MONROE	0	0	1,714	561,651	0	194.03
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)	2,448,007	0	285	5,640,859		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.586365	0.000000	0.001930	0.242165		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 2:24 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	BIO-MEDICAL (COST)	UTILITIES - HOSPITAL (SQUARE FEET)	UTILITIES - OFFSITE BLDGS (COST)	
			5.00	7.00	7.01	7.02	7.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	35,116,640					5.00
7.00	00700	OPERATION OF PLANT	1,512,365	109,034				7.00
7.01	00701	BIO-MEDICAL	168,335	436	15,001,510			7.01
7.02	00702	UTILITIES - HOSPITAL	837,835	0	0	85,778		7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	126,871	0	0	0	134,273	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	222,509	1,729	0	1,729	0	8.00
9.00	00900	HOUSEKEEPING	659,690	2,753	0	2,354	0	9.00
10.00	01000	DIETARY	406,051	700	0	700	0	10.00
11.00	01100	CAFETERIA	786,032	6,254	0	6,254	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,078,573	587	0	587	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,034,999	1,585	0	1,585	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	767,275	2,539	0	2,539	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,802,010	16,823	2,323,081	16,823	0	30.00
31.00	03100	INTENSIVE CARE UNIT	834,558	3,224	79,410	3,224	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,111,022	7,149	4,306	7,149	0	40.00
43.00	04300	NURSERY	266,812	1,695	159,173	1,695	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,266,494	10,965	3,514,279	10,965	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	214,610	1,185	121,598	1,185	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,211,853	8,855	6,627,280	8,855	0	54.00
60.00	06000	LABORATORY	3,020,057	3,926	667,917	3,212	0	60.00
65.00	06500	RESPIRATORY THERAPY	924,794	4,089	654,107	4,089	0	65.00
66.00	06600	PHYSICAL THERAPY	995,323	3,475	260,405	3,475	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,634	100	0	100	0	67.00
68.00	06800	SPEECH PATHOLOGY	170,363	50	0	50	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,168,926	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	786,555	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,701,354	0	0	0	0	73.00
76.00	03020	OP PSYCH	329,659	400	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	668,603	4,386	5,551	0	0	90.00
90.01	09001	CLINIC - AMO	709,311	1,955	0	0	4,987	90.01
90.02	09002	CLINIC - AMH NEURO	120,855	0	24,275	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	634,422	2,325	49,167	0	0	90.03
91.00	09100	EMERGENCY	1,836,060	5,407	106,900	5,407	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,470,869	4,323	374,965	0	10,415	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,149,679	96,915	14,972,414	81,977	15,402	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,464	654	0	654	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	1,171,734	6,951	29,096	3,147	15,075	194.01
194.02	07952	OTHER MOBS	956,293	2,800	0	0	95,808	194.02
194.03	07953	MONROE	825,470	1,714	0	0	7,988	194.03
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)	8,727,082	1,888,213	217,719	1,046,051	158,401	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.248517	17.317653	0.014513	12.194863	1.179694	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	464,537	547,629	15,097	11,083	1,678	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.013228	5.022553	0.001006	0.129206	0.012497	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 2:24 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	BIO-MEDICAL						7.01
7.02	00702	UTILITIES - HOSPITAL						7.02
7.03	00703	UTILITIES - OFFSITE BLDGS						7.03
8.00	00800	LAUNDRY & LINEN SERVICE	218,615					8.00
9.00	00900	HOUSEKEEPING	33,960	104,116				9.00
10.00	01000	DIETARY	2,590	700	20,934			10.00
11.00	01100	CAFETERIA	7,164	6,254	0	555,923		11.00
13.00	01300	NURSING ADMINISTRATION	0	587	0	24,754	204,596	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	1,585	0	15,268	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,539	0	20,530	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,571	16,823	13,449	74,445	74,445	30.00
31.00	03100	INTENSIVE CARE UNIT	7,919	3,224	2,190	21,597	21,597	31.00
40.00	04000	SUBPROVIDER - IPF	5,338	7,149	5,295	32,483	32,483	40.00
43.00	04300	NURSERY	11,751	1,695	0	5,527	5,527	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,268	10,965	0	39,830	39,830	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,350	1,185	0	4,534	4,534	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,891	8,855	0	35,419	0	54.00
60.00	06000	LABORATORY	119	3,926	0	45,990	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,731	4,089	0	25,331	0	65.00
66.00	06600	PHYSICAL THERAPY	11,141	3,475	0	33,101	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	100	0	15,709	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	50	0	4,356	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 PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	1,443	400	0	8,782	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,290	4,386	0	20,568	0	90.00
90.01	09001	CLINIC - AMO	30	1,955	0	13,631	0	90.01
90.02	09002	CLINIC - AMH NEURO	5	0	0	1,896	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	882	2,325	0	13,960	0	90.03
91.00	09100	EMERGENCY	29,893	5,407	0	26,180	26,180	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	9,020	4,323	0	51,489	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	217,356	91,997	20,934	535,380	204,596	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	654	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	725	6,951	0	20,543	0	194.01
194.02	07952	OTHER MOBS	76	2,800	0	0	0	194.02
194.03	07953	MONROE	458	1,714	0	0	0	194.03
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)	328,833	951,097	537,910	1,233,852	1,424,243	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.504165	9.134974	25.695519	2.219466	6.961246	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	80,582	86,866	65,680	179,235	37,937	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.368602	0.834319	3.137480	0.322410	0.185424	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 2:24 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	OTHER CAP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	BIO-MEDICAL					7.01
7.02	00702	UTILITIES - HOSPITAL					7.02
7.03	00703	UTILITIES - OFFSITE BLDGS					7.03
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	0				14.00
15.00	01500	PHARMACY	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,593,267		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	511,923		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	43,358		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	114,892		40.00
43.00	04300	NURSERY	0	0	2,224		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	146,246		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,824		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	18,246		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	13,703		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 PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0		73.00
76.00	03020	OP PSYCH	0	0	31,062		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	7,502		90.00
90.01	09001	CLINIC - AMO	0	0	12,980		90.01
90.02	09002	CLINIC - AMH NEURO	0	0	653		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	9,153		90.03
91.00	09100	EMERGENCY	0	0	658,105		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	100	1,571,871		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
194.00	07950	TITLE XX	0	0	0		194.00
194.01	07951	OTHER NRCC	0	0	14,225		194.01
194.02	07952	OTHER MOBS	0	0	4,342		194.02
194.03	07953	MONROE	0	0	2,829		194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,387,357	1,101,649		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	13,873.570000	0.691440		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	62,823	84,584		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	628.230000	0.053088		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 2:24 pm

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	5,597,689		5,597,689	0	5,597,689	30.00
31.00	03100	INTENSIVE CARE UNIT	1,464,150		1,464,150	0	1,464,150	31.00
40.00	04000	SUBPROVIDER - IPF	2,185,228		2,185,228	0	2,185,228	40.00
43.00	04300	NURSERY	470,891		470,891	0	470,891	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,825,869		3,825,869	0	3,825,869	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	373,960		373,960	0	373,960	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,322,596		3,322,596	0	3,322,596	54.00
60.00	06000	LABORATORY	4,025,561		4,025,561	0	4,025,561	60.00
65.00	06500	RESPIRATORY THERAPY	1,396,460	0	1,396,460	0	1,396,460	65.00
66.00	06600	PHYSICAL THERAPY	1,470,982	0	1,470,982	0	1,470,982	66.00
67.00	06700	OCCUPATIONAL THERAPY	419,071	0	419,071	0	419,071	67.00
68.00	06800	SPEECH PATHOLOGY	224,302	0	224,302	0	224,302	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,459,424		1,459,424	0	1,459,424	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	982,027		982,027	0	982,027	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,511,526		3,511,526	0	3,511,526	73.00
76.00	03020	OP PSYCH	465,306		465,306	0	465,306	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,003,641		1,003,641	0	1,003,641	90.00
90.01	09001	CLINIC - AMO	982,459		982,459	0	982,459	90.01
90.02	09002	CLINIC - AMH NEURO	155,910		155,910	0	155,910	90.02
90.03	09003	CLINIC - NIGLIAZZO	892,944		892,944	0	892,944	90.03
91.00	09100	EMERGENCY	3,243,226		3,243,226	0	3,243,226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	982,134		982,134		982,134	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,096,334		2,096,334	0	2,096,334	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	40,551,690	0	40,551,690	0	40,551,690	200.00
201.00		Less Observation Beds	982,134		982,134		982,134	201.00
202.00		Total (see instructions)	39,569,556	0	39,569,556	0	39,569,556	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 2:24 pm

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	5,057,080		5,057,080			30.00
31.00	03100	INTENSIVE CARE UNIT	1,559,745		1,559,745			31.00
40.00	04000	SUBPROVIDER - IPF	2,406,372		2,406,372			40.00
43.00	04300	NURSERY	264,830		264,830			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,135,867	5,545,529	7,681,396	0.498069	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	145,602	71,608	217,210	1.721652	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,003,205	17,601,114	19,604,319	0.169483	0.000000	54.00
60.00	06000	LABORATORY	3,315,655	13,974,532	17,290,187	0.232823	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,218,300	2,423,903	5,642,203	0.247503	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	303,204	2,626,656	2,929,860	0.502066	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	183,234	333,385	516,619	0.811180	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	92,929	358,519	451,448	0.496850	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,459,091	714,952	2,174,043	0.671295	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,352,827	249,988	1,602,815	0.612689	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,900,024	5,372,759	10,272,783	0.341828	0.000000	73.00
76.00	03020	OP PSYCH	0	650,586	650,586	0.715211	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,851,982	1,851,982	0.541928	0.000000	90.00
90.01	09001	CLINIC - AMO	0	3,204,331	3,204,331	0.306603	0.000000	90.01
90.02	09002	CLINIC - AMH NEURO	0	161,171	161,171	0.967358	0.000000	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	2,259,458	2,259,458	0.395203	0.000000	90.03
91.00	09100	EMERGENCY	481,856	2,591,718	3,073,574	1.055197	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,517,323	1,517,323	0.647281	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,222,410	3,222,410	0.650549	0.000000	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	28,879,821	64,731,924	93,611,745			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	28,879,821	64,731,924	93,611,745			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 2:24 pm

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
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.498069		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.721652		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169483		54.00
60.00	06000	LABORATORY	0.232823		60.00
65.00	06500	RESPIRATORY THERAPY	0.247503		65.00
66.00	06600	PHYSICAL THERAPY	0.502066		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.811180		67.00
68.00	06800	SPEECH PATHOLOGY	0.496850		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.671295		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.612689		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.341828		73.00
76.00	03020	OP PSYCH	0.715211		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.541928		90.00
90.01	09001	CLINIC - AMO	0.306603		90.01
90.02	09002	CLINIC - AMH NEURO	0.967358		90.02
90.03	09003	CLINIC - NIGLIAZZO	0.395203		90.03
91.00	09100	EMERGENCY	1.055197		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.647281		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.650549		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
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: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,597,689		5,597,689	0	5,597,689	30.00
31.00	03100	INTENSIVE CARE UNIT	1,464,150		1,464,150	0	1,464,150	31.00
40.00	04000	SUBPROVIDER - IPF	2,185,228		2,185,228	0	2,185,228	40.00
43.00	04300	NURSERY	470,891		470,891	0	470,891	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,825,869		3,825,869	0	3,825,869	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	373,960		373,960	0	373,960	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,322,596		3,322,596	0	3,322,596	54.00
60.00	06000	LABORATORY	4,025,561		4,025,561	0	4,025,561	60.00
65.00	06500	RESPIRATORY THERAPY	1,396,460	0	1,396,460	0	1,396,460	65.00
66.00	06600	PHYSICAL THERAPY	1,470,982	0	1,470,982	0	1,470,982	66.00
67.00	06700	OCCUPATIONAL THERAPY	419,071	0	419,071	0	419,071	67.00
68.00	06800	SPEECH PATHOLOGY	224,302	0	224,302	0	224,302	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,459,424		1,459,424	0	1,459,424	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	982,027		982,027	0	982,027	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,511,526		3,511,526	0	3,511,526	73.00
76.00	03020	OP PSYCH	465,306		465,306	0	465,306	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,003,641		1,003,641	0	1,003,641	90.00
90.01	09001	CLINIC - AMO	982,459		982,459	0	982,459	90.01
90.02	09002	CLINIC - AMH NEURO	155,910		155,910	0	155,910	90.02
90.03	09003	CLINIC - NIGLIAZZO	892,944		892,944	0	892,944	90.03
91.00	09100	EMERGENCY	3,243,226		3,243,226	0	3,243,226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	982,134		982,134		982,134	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,096,334		2,096,334	0	2,096,334	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	40,551,690	0	40,551,690	0	40,551,690	200.00
201.00		Less Observation Beds	982,134		982,134		982,134	201.00
202.00		Total (see instructions)	39,569,556	0	39,569,556	0	39,569,556	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Hospital | PPS

		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	5,057,080		5,057,080			30.00
31.00	03100	INTENSIVE CARE UNIT	1,559,745		1,559,745			31.00
40.00	04000	SUBPROVIDER - IPF	2,406,372		2,406,372			40.00
43.00	04300	NURSERY	264,830		264,830			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,135,867	5,545,529	7,681,396	0.498069	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	145,602	71,608	217,210	1.721652	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,003,205	17,601,114	19,604,319	0.169483	0.000000	54.00
60.00	06000	LABORATORY	3,315,655	13,974,532	17,290,187	0.232823	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,218,300	2,423,903	5,642,203	0.247503	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	303,204	2,626,656	2,929,860	0.502066	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	183,234	333,385	516,619	0.811180	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	92,929	358,519	451,448	0.496850	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,459,091	714,952	2,174,043	0.671295	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,352,827	249,988	1,602,815	0.612689	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,900,024	5,372,759	10,272,783	0.341828	0.000000	73.00
76.00	03020	OP PSYCH	0	650,586	650,586	0.715211	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,851,982	1,851,982	0.541928	0.000000	90.00
90.01	09001	CLINIC - AMO	0	3,204,331	3,204,331	0.306603	0.000000	90.01
90.02	09002	CLINIC - AMH NEURO	0	161,171	161,171	0.967358	0.000000	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	2,259,458	2,259,458	0.395203	0.000000	90.03
91.00	09100	EMERGENCY	481,856	2,591,718	3,073,574	1.055197	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,517,323	1,517,323	0.647281	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,222,410	3,222,410	0.650549	0.000000	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	28,879,821	64,731,924	93,611,745			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	28,879,821	64,731,924	93,611,745			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.498069		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.721652		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169483		54.00
60.00	06000	LABORATORY	0.232823		60.00
65.00	06500	RESPIRATORY THERAPY	0.247503		65.00
66.00	06600	PHYSICAL THERAPY	0.502066		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.811180		67.00
68.00	06800	SPEECH PATHOLOGY	0.496850		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.671295		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.612689		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.341828		73.00
76.00	03020	OP PSYCH	0.715211		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.541928		90.00
90.01	09001	CLINIC - AMO	0.306603		90.01
90.02	09002	CLINIC - AMH NEURO	0.967358		90.02
90.03	09003	CLINIC - NIGLIAZZO	0.395203		90.03
91.00	09100	EMERGENCY	1.055197		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.647281		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.650549		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,825,869	640,659	3,185,210	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	373,960	53,318	320,642	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,322,596	291,336	3,031,260	0	0	54.00
60.00	06000	LABORATORY	4,025,561	211,893	3,813,668	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,396,460	173,046	1,223,414	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,470,982	121,594	1,349,388	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	419,071	11,752	407,319	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	224,302	4,986	219,316	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,459,424	15,463	1,443,961	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	982,027	10,405	971,622	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,511,526	85,329	3,426,197	0	0	73.00
76.00	03020	OP PSYCH	465,306	11,717	453,589	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,003,641	45,752	957,889	0	0	90.00
90.01	09001	CLINIC - AMO	982,459	25,994	956,465	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	155,910	5,739	150,171	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	892,944	35,876	857,068	0	0	90.03
91.00	09100	EMERGENCY	3,243,226	238,847	3,004,379	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	982,134	127,264	854,870	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,096,334	185,129	1,911,205	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	30,833,732	2,296,099	28,537,633	0	0	200.00
201.00		Less Observation Beds	982,134	127,264	854,870	0	0	201.00
202.00		Total (line 200 minus line 201)	29,851,598	2,168,835	27,682,763	0	0	202.00

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

Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,825,869	7,681,396	0.498069		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	373,960	217,210	1.721652		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,322,596	19,604,319	0.169483		54.00
60.00	06000	LABORATORY	4,025,561	17,290,187	0.232823		60.00
65.00	06500	RESPIRATORY THERAPY	1,396,460	5,642,203	0.247503		65.00
66.00	06600	PHYSICAL THERAPY	1,470,982	2,929,860	0.502066		66.00
67.00	06700	OCCUPATIONAL THERAPY	419,071	516,619	0.811180		67.00
68.00	06800	SPEECH PATHOLOGY	224,302	451,448	0.496850		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,459,424	2,174,043	0.671295		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	982,027	1,602,815	0.612689		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,511,526	10,272,783	0.341828		73.00
76.00	03020	OP PSYCH	465,306	650,586	0.715211		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,003,641	1,851,982	0.541928		90.00
90.01	09001	CLINIC - AMO	982,459	3,204,331	0.306603		90.01
90.02	09002	CLINIC - AMH NEURO	155,910	161,171	0.967358		90.02
90.03	09003	CLINIC - NIGLIAZZO	892,944	2,259,458	0.395203		90.03
91.00	09100	EMERGENCY	3,243,226	3,073,574	1.055197		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	982,134	1,517,323	0.647281		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,096,334	3,222,410	0.650549		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000		97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	30,833,732	84,323,718			200.00
201.00		Less Observation Beds	982,134	0			201.00
202.00		Total (line 200 minus line 201)	29,851,598	84,323,718			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/26/2016 2:24 pm

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	640,659	7,681,396	0.083404	173,629	14,481	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,318	217,210	0.245468	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	291,336	19,604,319	0.014861	565,680	8,407	54.00
60.00	06000	LABORATORY	211,893	17,290,187	0.012255	1,305,584	16,000	60.00
65.00	06500	RESPIRATORY THERAPY	173,046	5,642,203	0.030670	1,441,924	44,224	65.00
66.00	06600	PHYSICAL THERAPY	121,594	2,929,860	0.041502	147,541	6,123	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,752	516,619	0.022748	91,031	2,071	67.00
68.00	06800	SPEECH PATHOLOGY	4,986	451,448	0.011044	58,297	644	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,463	2,174,043	0.007113	1,324,112	9,418	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,405	1,602,815	0.006492	175	1	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,329	10,272,783	0.008306	1,933,004	16,056	73.00
76.00	03020	OP PSYCH	11,717	650,586	0.018010	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	45,752	1,851,982	0.024704	0	0	90.00
90.01	09001	CLINIC - AMO	25,994	3,204,331	0.008112	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	5,739	161,171	0.035608	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	35,876	2,259,458	0.015878	0	0	90.03
91.00	09100	EMERGENCY	238,847	3,073,574	0.077710	8,022	623	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	127,264	1,517,323	0.083874	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	2,110,970	81,101,308		7,048,999	118,048	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/26/2016 2:24 pm

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	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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 PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/26/2016 2:24 pm

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	7,681,396	0.000000	0.000000	173,629	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	217,210	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,604,319	0.000000	0.000000	565,680	54.00
60.00	06000	LABORATORY	0	17,290,187	0.000000	0.000000	1,305,584	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,642,203	0.000000	0.000000	1,441,924	65.00
66.00	06600	PHYSICAL THERAPY	0	2,929,860	0.000000	0.000000	147,541	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	516,619	0.000000	0.000000	91,031	67.00
68.00	06800	SPEECH PATHOLOGY	0	451,448	0.000000	0.000000	58,297	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,174,043	0.000000	0.000000	1,324,112	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,602,815	0.000000	0.000000	175	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,272,783	0.000000	0.000000	1,933,004	73.00
76.00	03020	OP PSYCH	0	650,586	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,851,982	0.000000	0.000000	0	90.00
90.01	09001	CLINIC - AMO	0	3,204,331	0.000000	0.000000	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	161,171	0.000000	0.000000	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	2,259,458	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	3,073,574	0.000000	0.000000	8,022	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,517,323	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	81,101,308			7,048,999	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 2:24 pm

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	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
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 PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	OP PSYCH	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC - AMO	0	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/26/2016 2:24 pm

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	0.498069	0	1,259,091	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.721652	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169483	0	3,517,423	0	0	54.00
60.00	06000	LABORATORY	0.232823	0	1,674,747	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.247503	0	1,357,048	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.502066	0	783,153	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.811180	0	50,513	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.496850	0	32,861	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.671295	0	591,927	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.612689	0	69,343	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.341828	0	1,373,712	0	0	73.00
76.00	03020	OP PSYCH	0.715211	0	45,271	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.541928	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0.306603	0	132,548	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.967358	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.395203	0	0	0	0	90.03
91.00	09100	EMERGENCY	1.055197	0	624,614	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.647281	0	358,673	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.650549		0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)		0	11,870,924	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	11,870,924	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/26/2016 2:24 pm

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	627,114	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	596,143	0		54.00
60.00	06000	LABORATORY	389,920	0		60.00
65.00	06500	RESPIRATORY THERAPY	335,873	0		65.00
66.00	06600	PHYSICAL THERAPY	393,194	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	40,975	0		67.00
68.00	06800	SPEECH PATHOLOGY	16,327	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	397,358	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	42,486	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	469,573	0		73.00
76.00	03020	OP PSYCH	32,378	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - AMO	40,640	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0		90.03
91.00	09100	EMERGENCY	659,091	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	232,162	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Subtotal (see instructions)	4,273,234	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,273,234	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/26/2016 2:24 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	640,659	7,681,396	0.083404	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,318	217,210	0.245468	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	291,336	19,604,319	0.014861	1,735	26	54.00
60.00	06000	LABORATORY	211,893	17,290,187	0.012255	35,150	431	60.00
65.00	06500	RESPIRATORY THERAPY	173,046	5,642,203	0.030670	15,222	467	65.00
66.00	06600	PHYSICAL THERAPY	121,594	2,929,860	0.041502	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,752	516,619	0.022748	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,986	451,448	0.011044	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,463	2,174,043	0.007113	7,375	52	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,405	1,602,815	0.006492	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,329	10,272,783	0.008306	102,151	848	73.00
76.00	03020	OP PSYCH	11,717	650,586	0.018010	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	45,752	1,851,982	0.024704	0	0	90.00
90.01	09001	CLINIC - AMO	25,994	3,204,331	0.008112	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	5,739	161,171	0.035608	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	35,876	2,259,458	0.015878	0	0	90.03
91.00	09100	EMERGENCY	238,847	3,073,574	0.077710	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,517,323	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	1,983,706	81,101,308		161,633	1,824	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/26/2016 2:24 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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 PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/26/2016 2:24 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,681,396	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	217,210	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,604,319	0.000000	0.000000	1,735	54.00
60.00	06000	LABORATORY	0	17,290,187	0.000000	0.000000	35,150	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,642,203	0.000000	0.000000	15,222	65.00
66.00	06600	PHYSICAL THERAPY	0	2,929,860	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	516,619	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	451,448	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,174,043	0.000000	0.000000	7,375	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,602,815	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,272,783	0.000000	0.000000	102,151	73.00
76.00	03020	OP PSYCH	0	650,586	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,851,982	0.000000	0.000000	0	90.00
90.01	09001	CLINIC - AMO	0	3,204,331	0.000000	0.000000	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	161,171	0.000000	0.000000	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	2,259,458	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	3,073,574	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,517,323	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	81,101,308			161,633	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 2:24 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
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 PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	OP PSYCH	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC - AMO	0	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151330 | Component CCN: 15Z330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/26/2016 2:24 pm

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	0.498069	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.721652	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169483	0	0	0	0	54.00
60.00	06000	LABORATORY	0.232823	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.247503	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.502066	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.811180	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.496850	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.671295	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.612689	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.341828	0	0	0	0	73.00
76.00	03020	OP PSYCH	0.715211	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.541928	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0.306603	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.967358	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.395203	0	0	0	0	90.03
91.00	09100	EMERGENCY	1.055197	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.647281	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.650549		0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
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: 151330 | Component CCN: 15Z330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/26/2016 2:24 pm

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 PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OP PSYCH	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - AMO	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I | Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	723,250	0	723,250	5,200	139.09	30.00
31.00	INTENSIVE CARE UNIT	128,924		128,924	730	176.61	31.00
40.00	SUBPROVIDER - IPF	248,960	0	248,960	1,765	141.05	40.00
43.00	NURSERY	55,988		55,988	409	136.89	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	1,157,122		1,157,122	8,104		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	168	23,367	30.00
31.00	INTENSIVE CARE UNIT	15	2,649	31.00
40.00	SUBPROVIDER - IPF	162	22,850	40.00
43.00	NURSERY	30	4,107	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	375	52,973	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	640,659	7,681,396	0.083404	155,428	12,963	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,318	217,210	0.245468	32,652	8,015	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	291,336	19,604,319	0.014861	116,838	1,736	54.00
60.00	06000	LABORATORY	211,893	17,290,187	0.012255	277,388	3,399	60.00
65.00	06500	RESPIRATORY THERAPY	173,046	5,642,203	0.030670	172,796	5,300	65.00
66.00	06600	PHYSICAL THERAPY	121,594	2,929,860	0.041502	8,330	346	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,752	516,619	0.022748	4,500	102	67.00
68.00	06800	SPEECH PATHOLOGY	4,986	451,448	0.011044	1,094	12	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,463	2,174,043	0.007113	125,012	889	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,405	1,602,815	0.006492	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,329	10,272,783	0.008306	422,247	3,507	73.00
76.00	03020	OP PSYCH	11,717	650,586	0.018010	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	45,752	1,851,982	0.024704	0	0	90.00
90.01	09001	CLINIC - AMO	25,994	3,204,331	0.008112	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	5,739	161,171	0.035608	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	35,876	2,259,458	0.015878	0	0	90.03
91.00	09100	EMERGENCY	238,847	3,073,574	0.077710	58,870	4,575	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	127,264	1,517,323	0.083874	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	2,110,970	81,101,308		1,375,155	40,844	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,200	0.00	168	0		30.00
31.00	03100	INTENSIVE CARE UNIT	730	0.00	15	0		31.00
40.00	04000	SUBPROVIDER - IPF	1,765	0.00	162	0		40.00
43.00	04300	NURSERY	409	0.00	30	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	8,104		375	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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 PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,681,396	0.000000	0.000000	155,428	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	217,210	0.000000	0.000000	32,652	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,604,319	0.000000	0.000000	116,838	54.00
60.00	06000	LABORATORY	0	17,290,187	0.000000	0.000000	277,388	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,642,203	0.000000	0.000000	172,796	65.00
66.00	06600	PHYSICAL THERAPY	0	2,929,860	0.000000	0.000000	8,330	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	516,619	0.000000	0.000000	4,500	67.00
68.00	06800	SPEECH PATHOLOGY	0	451,448	0.000000	0.000000	1,094	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,174,043	0.000000	0.000000	125,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,602,815	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,272,783	0.000000	0.000000	422,247	73.00
76.00	03020	OP PSYCH	0	650,586	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,851,982	0.000000	0.000000	0	90.00
90.01	09001	CLINIC - AMO	0	3,204,331	0.000000	0.000000	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	161,171	0.000000	0.000000	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	2,259,458	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	3,073,574	0.000000	0.000000	58,870	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,517,323	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	81,101,308			1,375,155	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
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 PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	OP PSYCH	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC - AMO	0	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	640,659	7,681,396	0.083404	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,318	217,210	0.245468	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	291,336	19,604,319	0.014861	916	14	54.00
60.00	06000	LABORATORY	211,893	17,290,187	0.012255	36,377	446	60.00
65.00	06500	RESPIRATORY THERAPY	173,046	5,642,203	0.030670	9,827	301	65.00
66.00	06600	PHYSICAL THERAPY	121,594	2,929,860	0.041502	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,752	516,619	0.022748	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,986	451,448	0.011044	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,463	2,174,043	0.007113	2,592	18	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,405	1,602,815	0.006492	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,329	10,272,783	0.008306	60,050	499	73.00
76.00	03020	OP PSYCH	11,717	650,586	0.018010	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	45,752	1,851,982	0.024704	0	0	90.00
90.01	09001	CLINIC - AMO	25,994	3,204,331	0.008112	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	5,739	161,171	0.035608	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	35,876	2,259,458	0.015878	0	0	90.03
91.00	09100	EMERGENCY	238,847	3,073,574	0.077710	349	27	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,517,323	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	1,983,706	81,101,308		110,111	1,305	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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 PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,681,396	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	217,210	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,604,319	0.000000	0.000000	916	54.00
60.00	06000	LABORATORY	0	17,290,187	0.000000	0.000000	36,377	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,642,203	0.000000	0.000000	9,827	65.00
66.00	06600	PHYSICAL THERAPY	0	2,929,860	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	516,619	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	451,448	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,174,043	0.000000	0.000000	2,592	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,602,815	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,272,783	0.000000	0.000000	60,050	73.00
76.00	03020	OP PSYCH	0	650,586	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,851,982	0.000000	0.000000	0	90.00
90.01	09001	CLINIC - AMO	0	3,204,331	0.000000	0.000000	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	161,171	0.000000	0.000000	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	2,259,458	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	3,073,574	0.000000	0.000000	349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,517,323	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	81,101,308			110,111	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
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 PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	OP PSYCH	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC - AMO	0	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 2:24 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,325	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,200	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,285	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	125	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)	2,019	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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	129.14	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)	5,597,689	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)	16,142	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)	16,142	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,581,547	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)	5,581,547	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)	1,073.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,167,134	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)	2,167,134	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 2:24 pm

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	1,464,150	730	2,005.68	348	697,977	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)	2,578,283	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,443,394	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)	915	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,073.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	982,134	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 2:24 pm

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	723,250	5,581,547	0.129579	982,134	127,264	90.00
91.00	Nursing School cost	0	5,581,547	0.000000	982,134	0	91.00
92.00	Allied health cost	0	5,581,547	0.000000	982,134	0	92.00
93.00	All other Medical Education	0	5,581,547	0.000000	982,134	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/26/2016 2:24 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,765	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,765	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)	1,765	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)	332	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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)	2,185,228	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,185,228	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,185,228	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)	1,238.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	411,046	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)	411,046	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 2:24 pm

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	52,114	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	463,160	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)	1,824	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,824	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	461,336	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/26/2016 2:24 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	2,185,228	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,185,228	0.000000	0	0	91.00
92.00	Allied health cost	0	2,185,228	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,185,228	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,325	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,200	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,285	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	125	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)	168	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)	409	15.00
16.00	Nursery days (title V or XIX only)	30	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)	5,597,689	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)	5,597,689	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)	5,597,689	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)	1,076.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	180,849	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)	180,849	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	470,891	409	1,151.32	30	34,540	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,464,150	730	2,005.68	15	30,085	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)	559,532	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	805,006	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)	30,123	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	40,844	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	70,967	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	734,039	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)	915	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,076.48	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	984,979	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	723,250	5,597,689	0.129205	984,979	127,264	90.00
91.00	Nursing School cost	0	5,597,689	0.000000	984,979	0	91.00
92.00	Allied health cost	0	5,597,689	0.000000	984,979	0	92.00
93.00	All other Medical Education	0	5,597,689	0.000000	984,979	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/26/2016 2:24 pm
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,765	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,765	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)	1,765	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)	162	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)	409	15.00
16.00	Nursery days (title V or XIX only)	30	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)	2,185,228	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,185,228	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,185,228	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)	1,238.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	200,571	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)	200,571	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1

Component CCN: 15M330 | Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	33,691	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	234,262	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	22,850	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,305	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	24,155	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	210,107	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1

Component CCN: 15M330 | Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	248,960	2,185,228	0.113929	0	0	90.00
91.00	Nursing School cost	0	2,185,228	0.000000	0	0	91.00
92.00	Allied health cost	0	2,185,228	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,185,228	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/26/2016 2:24 pm

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		2,194,527		30.00
31.00	03100	INTENSIVE CARE UNIT		760,820		31.00
40.00	04000	SUBPROVIDER - IPF		79,547		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.498069	173,629	86,479	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.721652	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169483	565,680	95,873	54.00
60.00	06000	LABORATORY	0.232823	1,305,584	303,970	60.00
65.00	06500	RESPIRATORY THERAPY	0.247503	1,441,924	356,881	65.00
66.00	06600	PHYSICAL THERAPY	0.502066	147,541	74,075	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.811180	91,031	73,843	67.00
68.00	06800	SPEECH PATHOLOGY	0.496850	58,297	28,965	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.671295	1,324,112	888,870	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.612689	175	107	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.341828	1,933,004	660,755	73.00
76.00	03020	OP PSYCH	0.715211	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.541928	0	0	90.00
90.01	09001	CLINIC - AMO	0.306603	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.967358	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.395203	0	0	90.03
91.00	09100	EMERGENCY	1.055197	8,022	8,465	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.647281	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		7,048,999	2,578,283	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)		7,048,999		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/26/2016 2:24 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		404,764		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.498069	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.721652	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169483	1,735	294	54.00
60.00	06000	LABORATORY	0.232823	35,150	8,184	60.00
65.00	06500	RESPIRATORY THERAPY	0.247503	15,222	3,767	65.00
66.00	06600	PHYSICAL THERAPY	0.502066	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.811180	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.496850	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.671295	7,375	4,951	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.612689	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.341828	102,151	34,918	73.00
76.00	03020	OP PSYCH	0.715211	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.541928	0	0	90.00
90.01	09001	CLINIC - AMO	0.306603	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.967358	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.395203	0	0	90.03
91.00	09100	EMERGENCY	1.055197	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.647281	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		161,633	52,114	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)		161,633		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151330 | Component CCN: 15Z330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/26/2016 2:24 pm

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
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.498069	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.721652	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169483	0	0	54.00
60.00	06000	LABORATORY	0.232823	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.247503	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.502066	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.811180	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.496850	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.671295	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.612689	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.341828	0	0	73.00
76.00	03020	OP PSYCH	0.715211	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.541928	0	0	90.00
90.01	09001	CLINIC - AMO	0.306603	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.967358	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.395203	0	0	90.03
91.00	09100	EMERGENCY	1.055197	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.647281	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	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)		0		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		416,256		30.00
31.00	03100	INTENSIVE CARE UNIT		85,020		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		18,687		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.498069	155,428	77,414	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.721652	32,652	56,215	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169483	116,838	19,802	54.00
60.00	06000	LABORATORY	0.232823	277,388	64,582	60.00
65.00	06500	RESPIRATORY THERAPY	0.247503	172,796	42,768	65.00
66.00	06600	PHYSICAL THERAPY	0.502066	8,330	4,182	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.811180	4,500	3,650	67.00
68.00	06800	SPEECH PATHOLOGY	0.496850	1,094	544	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.671295	125,012	83,920	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.612689	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.341828	422,247	144,336	73.00
76.00	03020	OP PSYCH	0.715211	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.541928	0	0	90.00
90.01	09001	CLINIC - AMO	0.306603	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.967358	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.395203	0	0	90.03
91.00	09100	EMERGENCY	1.055197	58,870	62,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.647281	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		1,375,155	559,532	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)		1,375,155		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3

Component CCN: 15M330 | Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		479,603		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.498069	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.721652	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169483	916	155	54.00
60.00	06000	LABORATORY	0.232823	36,377	8,469	60.00
65.00	06500	RESPIRATORY THERAPY	0.247503	9,827	2,432	65.00
66.00	06600	PHYSICAL THERAPY	0.502066	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.811180	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.496850	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.671295	2,592	1,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.612689	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.341828	60,050	20,527	73.00
76.00	03020	OP PSYCH	0.715211	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.541928	0	0	90.00
90.01	09001	CLINIC - AMO	0.306603	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.967358	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.395203	0	0	90.03
91.00	09100	EMERGENCY	1.055197	349	368	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.647281	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		110,111	33,691	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)		110,111		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151330 | Component CCN: 15Z330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/26/2016 2:24 pm

Title XIX | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.498069	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.721652	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169483	0	0	54.00
60.00	06000	LABORATORY	0.232823	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.247503	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.502066	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.811180	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.496850	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.671295	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.612689	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.341828	0	0	73.00
76.00	03020	OP PSYCH	0.715211	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.541928	0	0	90.00
90.01	09001	CLINIC - AMO	0.306603	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.967358	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.395203	0	0	90.03
91.00	09100	EMERGENCY	1.055197	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.647281	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151330	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/26/2016 2:24 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,273,234	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)	4,273,234	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)	4,315,966	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)	41,219	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,041,703	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)	2,233,044	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)	2,233,044	30.00
31.00	Primary payer payments	142	31.00
32.00	Subtotal (line 30 minus line 31)	2,232,902	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)	271,905	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	176,738	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	271,905	36.00
37.00	Subtotal (see instructions)	2,409,640	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)	2,409,640	40.00
40.01	Sequestration adjustment (see instructions)	48,193	40.01
41.00	Interim payments	2,185,145	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	176,302	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: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I Date/Time Prepared: 5/26/2016 2:24 pm

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		4,499,278		2,185,145	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,499,278		2,185,145	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		612,005		176,302	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		5,111,283		2,361,447	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: 151330 | Component CCN: 15M330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2016 2:24 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		233,508		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)		233,508		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		1		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		233,509		0	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151330 | Component CCN: 15Z330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2016 2:24 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151330	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/26/2016 2:24 pm
	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	1,590	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,367	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	593	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	5,015	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	93,611,745	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,137,292	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: 151330 Component CCN: 15Z330	Period: From 01/01/2015 To 12/31/2015	Worksheet E-2 Date/Time Prepared: 5/26/2016 2:24 pm
	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)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	0	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	0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
20.00	Interim payments	0	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151330 Component CCN: 15Z330	Period: From 01/01/2015 To 12/31/2015	Worksheet E-2 Date/Time Prepared: 5/26/2016 2:24 pm
	Title XIX	Swing Beds - SNF	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151330	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part V Date/Time Prepared: 5/26/2016 2:24 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,443,394	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)	5,443,394	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,497,828	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)	5,497,828	19.00
20.00	Deductibles (exclude professional component)	498,740	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,999,088	22.00
23.00	Coinsurance	4,095	23.00
24.00	Subtotal (line 22 minus line 23)	4,994,993	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	339,387	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	220,602	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	339,387	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,215,595	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)	5,215,595	30.00
30.01	Sequestration adjustment (see instructions)	104,312	30.01
31.00	Interim payments	4,499,278	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)	612,005	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: 151330 Component CCN: 15M330	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part II Date/Time Prepared: 5/26/2016 2:24 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	273,642	1.00
2.00	Net IPF PPS Outlier Payments	2,389	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	4.835616	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	276,031	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	276,031	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	276,031	18.00
19.00	Deductibles	37,756	19.00
20.00	Subtotal (line 18 minus line 19)	238,275	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	238,275	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	238,275	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	238,275	31.00
31.01	Sequestration adjustment (see instructions)	4,766	31.01
32.00	Interim payments	233,508	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	2,389	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151330	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2016 2:24 pm
	Title XIX	Hospital	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	357,977		8.00
9.00	Ancillary service charges	1,375,155	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,733,132	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,733,132	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,733,132	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	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)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2016 2:24 pm
	Title XIX	Subprovider - IPF	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	347,823		8.00
9.00	Ancillary service charges	110,111	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	457,934	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	457,934	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	457,934	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	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)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/26/2016 2:24 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	544,855	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,766,646	0	0	0	4.00
5.00	Other receivable	-6,573,122	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	2,013,391	0	0	0	6.00
7.00	Inventory	662,930	0	0	0	7.00
8.00	Prepaid expenses	104,344	0	0	0	8.00
9.00	Other current assets	119,621	0	0	0	9.00
10.00	Due from other funds	-1,442,429	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9,196,236	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	367,244	0	0	0	12.00
13.00	Land improvements	1,624,680	0	0	0	13.00
14.00	Accumulated depreciation	-1,370,185	0	0	0	14.00
15.00	Buildings	38,317,830	0	0	0	15.00
16.00	Accumulated depreciation	-15,927,871	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	4,591,700	0	0	0	19.00
20.00	Accumulated depreciation	-2,404,774	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	23,447,242	0	0	0	23.00
24.00	Accumulated depreciation	-18,143,541	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)	30,502,325	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,481,256	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	6,133,884	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,615,140	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	48,313,701	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,792,206	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,504,683	0	0	0	38.00
39.00	Payroll taxes payable	565,987	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				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)	8,862,876	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	32,500,958	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	32,500,958	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	41,363,834	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	6,949,867				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	6,949,867	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	48,313,701	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/26/2016 2:24 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		10,200,918		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,426,787				2.00
3.00	Total (sum of line 1 and line 2)		8,774,131		0		3.00
4.00		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)		8,774,131		0		11.00
12.00	CHANGE IN PY FUND BALANCE	1,824,264		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)		1,824,264		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		6,949,867		0		19.00

		Endowment Fund	Plant Fund			19.00
		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			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	CHANGE IN PY FUND BALANCE		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: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2016 2:24 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,321,910		5,321,910	1.00
2.00	SUBPROVIDER - IPF	2,406,372		2,406,372	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	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,728,282		7,728,282	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,559,745		1,559,745	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)	1,559,745		1,559,745	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,288,027		9,288,027	17.00
18.00	Ancillary services	17,705,035	51,388,808	69,093,843	18.00
19.00	Outpatient services	481,856	11,585,982	12,067,838	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		0	0	22.00
23.00	AMBULANCE SERVICES	0	3,222,410	3,222,410	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PROFESSIONAL FEES	4,404,997	2,864,561	7,269,558	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	31,879,915	69,061,761	100,941,676	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		50,804,962		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		50,804,962		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 151330 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-3 | Date/Time Prepared: 5/26/2016 2:24 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	100,941,676	1.00
2.00	Less contractual allowances and discounts on patients' accounts	55,262,523	2.00
3.00	Net patient revenues (line 1 minus line 2)	45,679,153	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	50,804,962	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,125,809	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	376,719	6.00
7.00	Income from investments	139,494	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	425,883	14.00
15.00	Revenue from rental of living quarters	4,650	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	160,135	17.00
18.00	Revenue from sale of medical records and abstracts	27,454	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	362,425	22.00
23.00	Governmental appropriations	461,571	23.00
24.00	MISC	187,062	24.00
24.01	TRANSPORTATION REVENUE	45	24.01
24.02	WORTHMAN FITNESS CENTER	85,992	24.02
24.03	MANAGEMENT REVENUE	125,937	24.03
24.04	CEDIT REVENUE	1,341,651	24.04
24.05	ROUNDING	4	24.05
24.06		0	24.06
24.07		0	24.07
24.08		0	24.08
25.00	Total other income (sum of lines 6-24)	3,699,022	25.00
26.00	Total (line 5 plus line 25)	-1,426,787	26.00
27.00		0	27.00
27.01		0	27.01
27.02		0	27.02
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)	-1,426,787	29.00